MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

P6385

Reg. Dist. No. 26

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Beverly Beach
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mayo

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Prince George
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lanham
STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED (Type or Print): (First) Nellie (Middle) (Last) Dinge (FINGE)

4. DATE OF DEATH: (Month) July (Day) 3 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: about 1881

9. AGE last birthday: 68 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: House

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. William Hebns

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute Dilatation of Heart	sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardio - renal disease	uncertain
	(c)	

442
131a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John M. Claffy M.D. Deputy Medical Examiner, Annapolis Md 7/3/49.

23. BURIAL, CREMATION REMOVAL (Specify): Removal

DATE THEREOF: July 3 1949

NAME OF CEMETERY OR CREMATORY: Wm Schlemm Funeral Home

LOCATION (City, town, or county) (State): 535 Bergen Ave. Union City N.J.

DATE REC'D BY LOCAL REG.: July 3 - 1949

REGISTRAR'S SIGNATURE: L. B. Dent.

24. FUNERAL DIRECTOR: Gasch Funeral Home

ADDRESS: Hyattsville Md

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

RECEIVED
JUL 6 1949
BUREAU V. S.

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

P6386

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Odenton
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Odenton, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Odenton
STREET ADDRESS (If rural give location) ------

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) MARTHA ELIZABETH BEACH

4. DATE OF DEATH (Month) (Day) (Year) July 7, 1949 19

5. SEX Female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow
8. DATE OF BIRTH Dec. 29, 1880
9. AGE last birthday 68 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas Stewart Uhler
14. MOTHER'S MAIDEN NAME Clara Bergess

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Mrs. J. Watts, Odenton, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Ac. Myocardial Insuff.	24 hrs.
260 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Myocarditis	2 mos.
61	(c) Diabetes, mellitus	7 yrs.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 6, 1949 to July 7 1949 that I last saw the deceased alive on July 7, 1949 and that death occurred at 6 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Mark Shipley, M.D. ADDRESS Savage, Md. DATE SIGNED 7/7/49

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL Cremation
DATE THEREOF 7/9/49
NAME OF CEMETERY OR CREMATORY Epiphany
LOCATION (City, town, or county) (State) Odenton, Md.

DATE REC'D BY LOCAL REG. 7/8/49
REGISTRAR'S SIGNATURE H W Hedrick Dm

24. FUNERAL DIRECTOR Chas. G. Evans & Son, Inc. ADDRESS 118 W. Mount Royal ave. Balto.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

06387

Reg. Dist. No. 2-1

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasadena P.O
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Riviera Beach

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 3327 Cliftmont Ave

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) JAMES - ALBERT - BEVANS
4. DATE OF DEATH (Month) (Day) (Year) July 26 1949
5. SEX male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH Oct 11, 1903
9. AGE last birthday 45 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mr Man
10b. KIND OF BUSINESS OR INDUSTRY Chemicals & Pigments
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Albert Bejran
14. MOTHER'S MAIDEN NAME Mary Dobek
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY No. 212-10-6606
17. INFORMANT Mrs. Blanche M. Bevan

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
420.1	Immediate cause	(a) Coronary occlusion	sudden
94a	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	unknown
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John McCaffy M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 7-26-49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 7/30/49 NAME OF CEMETERY OR CREMATORY New Cathedral LOCATION (City, town, or county) Edmonson Ave. (State)

DATE REC'D BY LOCAL REG. 7/29/49 REGISTRAR'S SIGNATURE A. W. [signature]

24. FUNERAL DIRECTOR Schimunek Funeral Home ADDRESS 2601 E. Madison St.,

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

P6388

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Johnson's Clinic (Anne Arundel) MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Johnson's Clinic

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.C.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Parole
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Joseph Melvin Bias	7	1	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	If under 24 hrs. Hours	Min.
Male	Colored	Single	7/1/49	yrs.		5 hrs	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		Johnson' Maternity Clinic	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Edgar Bias	Catherine Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

762.0 **Immediate cause** (a) Atelectasis of Lungs — Interval between onset and death: 5 hrs.

161a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	No	Yes ☐ No ☐ X

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
No	No			

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 7/1/49, 19....., to 7/1/49, 19....., that I last saw the deceased alive on 7/1/49, 19....., and that death occurred at 6?20 P. m., from the causes and on the date stated above.

SIGNATURE Theodore A. Johnson M.D. (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION / REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	7-5-49	Brewer's Hill	Annapolis, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 5, 1949	[illegible]	William A. Reese, II	Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 6 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH Bc 06389

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 98

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Balt. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): 2 years 11 mos.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore City
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): not known ✓

3. NAME OF DECEASED (Type or Print) (First) Margaret (Middle) (Last) Black	4. DATE OF DEATH (Month) 7/1/49 (Day) (Year) 19
5. SEX: female — 6. COLOR OR RACE: colored — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed — 8. DATE OF BIRTH: about 1885 not known	9. AGE last birthday: 64(?) yrs. — If under 1 year: Months. Days — If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework — 10b. KIND OF BUSINESS OR INDUSTRY: none	11. BIRTHPLACE (State or foreign country): Alabama — 12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: John Haines	14. MOTHER'S MAIDEN NAME: Mary (last name unknown)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) — 16. SOCIAL SECURITY NO.	17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic Myocarditis	known since 6/9/49
422.2 Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Senile Psychosis	known since 8/12/46

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/12/46, 19....., to 7/1/49, 19....., that I last saw the deceased alive on 7/1/49, 19....., and that death occurred at 3:00 P.M. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Mayerstein	M.D.	Crownsville, Maryland	7/1/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	7-6-49	Mt. Calvary Cemetery	Balto.	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
7/6/49	H.W. Hedrick	Leonard Whalen	918 Pine St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Change of name:: letter from Doctor filmed G121 August 30 1949 L

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06390

CERTIFICATE OF DEATH

Reg. Dist. No. 21

The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Woodland Beach; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) George (Middle) WILLIAM E. (Last) Boswell

4. DATE OF DEATH: (Month) 7 (Day) 7 (Year) 1949

5. SEX: male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: Nov. 3 - 1884

9. AGE last birthday: 64 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Boiler maker

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Geo. E. Boswell

14. MOTHER'S MAIDEN NAME: Eliza J. Howe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Frances Keyser

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) arteriosclerotic cardio-vascular renal disease — Interval between onset and death: 1 yr (?)

442 Antecedent cause(s)

131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 25, 1949, to July 7, 1949, that I last saw the deceased alive on July 6, 1949, and that death occurred at 2 00 a m., from the causes and on the date stated above.

SIGNATURE: S. Boswell (Degree or title) M.D | ADDRESS: Annapolis Md | DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	7/9/49	Congressional Cemetery	Wash. D C

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
7-9-49	Th. Wm. J. French M.R.G.	Wm J. Nalley	3200 - R. I. ave. Mt Rainier, Md.

RECEIVED
JUL 12 1949
BUREAU V. S.

July 9 1949

To Dr O. W. Hedrick

Inclose Herwith Death Certificate of

George E. Boswell who Died at

Emergency Hospital, Annapolis Md

Jul 7, 1949. Has Been Deposited with me By

Funeral Director Wm J Nalley

3200 Rhode Island ave Mt Rainier Md

Resp James Severy

Hyattsville Md

06391

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital, Annapolis, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Virginia COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Blacksburg
STREET ADDRESS (If rural give location) Rural - Box 285

3. NAME OF DECEASED (Type or Print) (First) Nannie (Middle) Rice (Last) Bowman
4. DATE OF DEATH (Month) 7 (Day) 6 (Year) 1949

5. SEX Female
6. COLOR OR RACE White-US
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH 2-16-1888
9. AGE last birthday 61 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY Housewife
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Rodrick Wilbur Rice
14. MOTHER'S MAIDEN NAME Margaret Mitchell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Daughter of deceased Mrs T. Seligman Carvel Hall Annapolis Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Uremia	2 weeks
443 Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive Cardio Vascular Disease	10 years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 27, 1949, to July 6, 1949, that I last saw the deceased alive on July 6, 1949, and that death occurred at 9:00 A. m., from the causes and on the date stated above.

SIGNATURE G. N. Schiff (Degree or title) G.N. SCHIFF, CDR., MC, USN
ADDRESS USNH, Annapolis, Maryland
DATE SIGNED 7-6-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 7-8-1949
NAME OF CEMETERY OR CREMATORY U.S. Naval Academy
LOCATION (City, town, or county) (State) Annapolis, Maryland

DATE REC'D BY LOCAL REG. July 6, 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR John M. Taylor & Son
ADDRESS Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 7 1949
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06392

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Anne Arundel

City or town Baltimore Brooklyn Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, Institution, or street address where death occurred:

5216 4th Ave.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Anne Arundel

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5216 4th Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Laura Elizabeth Brockmeier

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
fem	wh.	wid

6.(b) Name of husband or wife Frank E Brockmeier

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 25th 1873

8. AGE: Years	Months	Days	If less than one day
75	5	13	..... hrs. ..... min.

9. Birthplace Sheboygan Co. Wis.

(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER 12. Name Nicholas Severinas

13. Birthplace Germany

MOTHER 14. Maiden name Anna M. Bader

15. Birthplace Germany

16. Informant Mrs. M. Louise Glaser Sister

Address 5216 4th Ave. Baltimore 25

17. Buried (Burial, cremation, or removal. Which?) Date thereof 7/14/49 (month) (day) (year)

Cemetery or crematory Oakland

Location Freeport Rd.

18. Funeral director Pulhamus Co. Inc.

Address 1214 E. Lanvale St.

19. 7/14 1949 a. w. Heinecke

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1949 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 27 1947, to July 11 1949 and that I last saw h. alive on July 11th 1949

Immediate cause of death	DURATION
Cerebral hemorrhage	1½ days
Due to Hypertension	
Due to Cardiac decompensation	2
Due to Senility.	
Other conditions Heart block.	

443 (Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Henry C Hemmeter M.D.

M. D. or other

Address 1075 Belvedere Ave Date signed 7-12-49

06393

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 165 Conduit Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 165 Conduit Street

3. NAME OF DECEASED (Type or Print) (First) Rose (Middle) Anna (Last) Burtis

4. DATE OF DEATH (Month) 7 (Day) 12 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH 2-22-1874
9. AGE last birthday 75 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work
10b. KIND OF BUSINESS OR INDUSTRY House
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Wm. Henry Burtis
14. MOTHER'S MAIDEN NAME Emily Holladioke

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Emily Shaw

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma Rectum with metastasis to Intestines & Ribs. — INTERVAL BETWEEN ONSET AND DEATH: 3 years.

154 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

46d (c) Arteriosclerosis Generalized — unknown

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept, 1945, to July 12, 1949, that I last saw the deceased alive on July 11, 1949, and that death occurred at 155A m., from the causes and on the date stated above.

SIGNATURE George C Basil (Degree or title) M.D. ADDRESS Annapolis Md DATE SIGNED 7-12-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 7-14-1949
NAME OF CEMETERY OR CREMATORY Cedar Bluff
LOCATION (City, town, or county) Annapolis, (State) Maryland

DATE REC'D BY LOCAL REG. July 14, 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR John M. Taylor & Son, ADDRESS Annapolis, Md.

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 15 1949
BUREAU V. S.

Dr. Bosil

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06394

Reg. Dist. No. 21

1. PLACE OF DEATH COUNTY A. A. Md MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md.
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location) 13 Loucas Ave

3. NAME OF DECEASED (Type or Print) (First) William (Middle) Lee (Last) Burtis

4. DATE OF DEATH (Month) 7 (Day) 19 (Year) 1949

5. SEX Male — 6. COLOR OR RACE White — 7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify) — 8. DATE OF BIRTH May 24-1896 — 9. AGE last birthday 53 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) U.S. Naval Academy — 10b. KIND OF BUSINESS OR INDUSTRY FOREMAN — 11. BIRTHPLACE (State or foreign country) Annapolis Md. — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Edward Burtis — 14. MOTHER'S MAIDEN NAME Ella L. Thompson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes — (If year, give war or dates of service) World W.I. — 16. SOCIAL SECURITY NO. — 17. INFORMANT Dorothea M. Burtis

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Thrombosis — 1/2 hour

420.1 Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterio Sclerosis (Moderate) — unknown

(c) Hypertension — 1 year

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 430-7-19, 1949, to 5 pm 7-19-49, that I last saw the deceased alive on 7-19, 1949, and that death occurred at 5 P m., from the causes and on the date stated above.

SIGNATURE George C. Bosil (Degree or title) M D — ADDRESS Annapolis Md — DATE SIGNED 7-20-49

23. BURIAL, ~~CREMATION~~ ~~REMOVAL (Specify)~~ — DATE 7-22-49 — NAME OF CEMETERY OR CREMATORY Cedar Bluff — LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. July 21, 1949 — REGISTRAR'S SIGNATURE [signature] — 24. FUNERAL DIRECTOR John M. Taylor Son — ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
BUREAU V. S.

06395

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 65 East Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 65 East Street

3. NAME OF DECEASED (Type or Print) (First) Joseph (Middle) G. (Last) Campbell

4. DATE OF DEATH (Month) July (Day) 13 (Year) 1949

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH May 24 1894
9. AGE last birthday 55 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tinsmith
10b. KIND OF BUSINESS OR INDUSTRY Roofing
11. BIRTHPLACE (State or foreign country) Annapolis, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William E. Campbell
14. MOTHER'S MAIDEN NAME Mary E. Puckett

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) World War I
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Ursula H. Campbell

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
420.1	Immediate cause	(a) Coronary occlusion	sudden
94a	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	unknown
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Caffy M.D., Deputy Medical Examiner (Degree or title) ADDRESS Annapolis Md. DATE SIGNED 7-13-49

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE THEREOF July 15, 1949 NAME OF CEMETERY OR CREMATORY St. Mary's LOCATION (City, town, or county) Annapolis, Md (State)

DATE REC'D BY LOCAL REG. July 14, 1949 REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR John M. Taylor + Son ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JUL 15 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH Be 16396

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis R.F.D #2 | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Whitehall Beach

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 118 Kossuth

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Ruth	Elaine	Cavey	July	23	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	single	Oct. 14, 1935	13 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
student		Baltimore Md	U.S.A.

13. FATHER'S NAME Lawrence Cavey — 14. MOTHER'S MAIDEN NAME Birdie Weidner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
none	none	Mrs. Birdie Cavey 118 N. Kossuth St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Accidental Drowning

929.4 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

183 (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, or other public place) OF INJURY Whitehall Beach	(CITY OR TOWN) Annapolis R.F.D #2	(COUNTY) H.H.	(STATE) Md

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at work ☐	Not while at work ☑	HOW DID INJURY OCCUR?
July	23	1949	6:45 p.m.			Stepped off sand-bar into deep water. Could Not Swim.

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John M. Caffey M.D	Deputy Medical Examiner	Annapolis Md	7-23-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	7/27/49	Lorraine Cem.	Woodlawn, Md.	

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
7-25-49	H.W. Nedrich	WM. J. TICKNER & SONS	Balto., Md.

wh

MARYLAND STATE DEPARTMENT OF HEALTH Bc

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

06397

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis R.F.D.#2 — LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Whitehall Beach

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural give location) 118 North Kossuth

3. NAME OF DECEASED (Type or Print): (First) Virginia (Middle) Lee (Last) Cavey

4. DATE OF DEATH: (Month) July (Day) 23 (Year) 1949

5. SEX: female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): single

8. DATE OF BIRTH: June 24, 1934

9. AGE last birthday: 15 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: Junior High School

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Lawrence Cavey

14. MOTHER'S MAIDEN NAME: Birdie Weidner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: no

17. INFORMANT: Mrs. Birdie Cavey 118 N. Kossuth St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Drowning

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Accidental

929.4
183

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office building, etc.) OF INJURY Whitehall Creek — (CITY OR TOWN) RFD #2 Annapolis — (COUNTY) A. A. Co. — (STATE) Md.

TIME OF INJURY (Month) July (Day) 23 (Year) 1949 (Hour) 5:15 p. m.

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR? Could not swim Stepped off sand bar into deep water

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) John M. Coffey M.D., Deputy Medical Examiner — ADDRESS Annapolis, Md — DATE SIGNED 7-23-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial. — DATE THEREOF 7/27/49 — NAME OF CEMETERY OR CREMATORY: Lorraine Cem. — LOCATION (City, town, or county) (State): Woodlawn, Md.

DATE REC'D BY LOCAL REG. 7-25-49 — REGISTRAR'S SIGNATURE A. W. Nedrich

24. FUNERAL DIRECTOR: WM. J. TICKNER & SONS — ADDRESS: Balto., Md.

6043

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

D6398

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jacobsville
LENGTH OF STAY (in this place) 5 mos
HOSPITAL OR INSTITUTION OR STREET ADDRESS 88 Mountain Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jacobsville
STREET ADDRESS (If rural, give location) 88 Mountain Road

3. NAME OF DECEASED (Type or Print): (First) Mildred (Middle) Helen (Last) Cheeves

4. DATE OF DEATH: (Month) July (Day) 2 (Year) 19 49

5. SEX female | 6. COLOR OR RACE negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) — | 8. DATE OF BIRTH Feb. 2. 1949 | 9. AGE last birthday yrs. | If under 1 year: Months 5, Days, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — | 10b. KIND OF BUSINESS OR INDUSTRY — | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME Leon Edward Cheeves | 14. MOTHER'S MAIDEN NAME Leona Rebecca Mackey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) — | 16. SOCIAL SECURITY NO. | 17. INFORMANT Lenona R. Cheeves

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Convulsions	Sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Diarrhoea	3 weeks
	(c) Acute Bronchitis	3 weeks

5711.0
119a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John M. Caffy M.D., Deputy Medical Examiner Annapolis, Md 7/2/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF 7-5-49 | NAME OF CEMETERY OR CREMATORY Mt Calvary | LOCATION (City, town, or county) (State) Edgewood, Md.

DATE REC'D BY LOCAL REG. July 5, 1949 | REGISTRAR'S SIGNATURE [illegible] | 24. FUNERAL DIRECTOR William Rose, II | ADDRESS Annapolis, Md.

RECEIVED
JUL 6 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH BC

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06399

Reg. Dist. No. 28

1. PLACE OF DEATH COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY B. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital	STREET ADDRESS (If rural, give location) 528 W. Lee Street

3. NAME OF DECEASED (Type or Print) (First) Ethel (Middle) (Last) Coates

4. DATE OF DEATH (Month) (Day) (Year) 7/17/49 19

5. SEX female

6. COLOR OR RACE colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH 1882

9. AGE last birthday 67 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework

10b. KIND OF BUSINESS OR INDUSTRY none

11. BIRTHPLACE (State or foreign country) not known

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME not known

14. MOTHER'S MAIDEN NAME not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ~~(If year, give war or dates of service)~~

16. SOCIAL SECURITY NO. ~~*****~~

17. INFORMANT Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) General Paresis

025

Antecedent cause(s)

30b

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH known since admission

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION ~~*****~~

19b. MAJOR FINDINGS OF OPERATION ~~*****~~

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) ~~*****~~

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY ~~****~~ (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) ~~*****~~

INJURY OCCURRED While at Work ☐ Not While At Work ☐ ~~*****~~

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/9/47, 19....., to 7/17/49, 19....., that I last saw the deceased alive on 7/17/49, 19....., and that death occurred at 2:00 P.M. m., from the causes and on the date stated above.

SIGNATURE Jacob Manguster M.D. (Degree or title) ADDRESS Crownsville, Md. DATE SIGNED 7/17/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 7/29.49 NAME OF CEMETERY ~~OR CREMATORY~~ Hospital LOCATION (City, town, or county) Crownsville Md (State)

DATE REC'D BY LOCAL REG. 7/29-49 REGISTRAR'S SIGNATURE E. F. Joyce Local Reg.

24. FUNERAL DIRECTOR Supt Hospital ADDRESS Crownsville Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 30 1949
BUREAU V. S.

P6480

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 21 –

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

V. S. No. 1

[1] PLACE OF DEATH

County Anne Arundel

Village or City Severna Park, (No. ____ St.: ____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

[2] FULL NAME Robert Emmitt Cooney, Jr. S.S.# 219-10-9087 A

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Male.	White	Married.

6 DATE OF BIRTH: Aug 11, (Month) (Day) 1870 (Year)

7 AGE: 79 yrs. 11 mos. ____ ds. If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work: Contractor (Retired)
(b) General nature of industry business, or establishment in which employed or (employer): Electrical Work.

9 BIRTHPLACE (State or country): Kentucky

PARENTS

10 NAME OF FATHER: Michel Cooney.

11 BIRTHPLACE OF FATHER (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Ellen Mc Grath

13 BIRTHPLACE OF MOTHER (State or Country): Ireland.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. E. Cooney, Jr.

(Address) Severna Park. Md.

15 Filed 7/12/49 A. W. Hesselbach Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July 11, 1949 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from April 1 1949 to July 11, 1949, that I last saw h[im] alive on July 9, 1949, and that death occurred on the data stated above, at 6 A. m.

The CAUSE OF DEATH * was as follows:

Carcinoma of the Prostate Gland

177 (Duration) 2 yrs. ____ mos. ____ ds.

Contributory 515 Lobar Pneumonia,
Secondary

(Duration) ____ yrs. ____ mos. 3 ds.

(Signed) James S. Bellinger M. D.

July 11 1949 (Address) Glen Burnie. Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Reeent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Lorelei Park. Balto Md — DATE OF BURIAL: July 13, 1949

20 UNDERTAKER: Wm. Cook. Inc. — ADDRESS: Balto. Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public Health Association.)

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At Home,* and children, not gainfully employed, as *At school, or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus; *Farmer (retired 6 yrs).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia, Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum,* etc., *Carcinoma, Sarcoma,* etc., of .....: (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicaemia,*" "PUERPERAL *peritonitis,*" *etc.* State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

C6481

Reg. Dist. No. 20

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN near Mayo - ; LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glebe (Heights) Creek

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE D.C. ; COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 5516 Call Place

3. NAME OF DECEASED (Type or Print): (First) Jack (Middle) Willie (Last) Crawford
4. DATE OF DEATH: (Month) July (Day) 10 (Year) 1949
5. SEX: male
6. COLOR OR RACE: negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: July 5, 1926
9. AGE last birthday: 23 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer. World War II
10b. KIND OF BUSINESS OR INDUSTRY: Gardening
11. BIRTHPLACE (State or foreign country): D.C.
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: Willie Crawford
14. MOTHER'S MAIDEN NAME: ?
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): World War II
16. SOCIAL SECURITY NO.
17. INFORMANT: Lloyd Mouton

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

929.8 **Immediate cause** (a) Drowning — INTERVAL BETWEEN ONSET AND DEATH

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
183 (b) accidental
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Glebe Creek
(CITY OR TOWN) near Mayo (COUNTY) Anne Arundel (STATE) Md
TIME OF INJURY (Month) July (Day) 10 (Year) 1949 (Hour) 5 P.m.
INJURY OCCURRED While at work ☐ Not while at work ☑
HOW DID INJURY OCCUR? went in Swimming after eating a heavy meal

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: John M. Caffy M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 7-10-49

23. BURIAL, CREMATION, REMOVAL (Specify): Removal
DATE THEREOF: 7-10-49
NAME OF CEMETERY OR CREMATORY
LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG.: July 10, 1949
REGISTRAR'S SIGNATURE: Edward Collmann
24. FUNERAL DIRECTOR: Rollin Funeral Home
ADDRESS: Washington D.C

Armistead 7672
Willie Crawford

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06402

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: Anne Arundel East Port

County ~~Anne Arundel~~

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 69 yrs. - 11 Mos. - 5 days

Hospital, institution, or street address where death occurred:

622 - 2nd Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County East Port

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 622 - 2nd Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Agus Crowdy

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife Sarah Crowdy

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 17, 1879

8. AGE:

Years	Months	Days	If less than one day
69	11	5	..... hrs. ..... min.

9. Birthplace Annapolis A.C. Maryland (Town, county, and state)

10. Usual occupation Oyster-man

11. Industry or business

FATHER

12. Name Daniel Crowdy

13. Birthplace Calvert Co., Md.

MOTHER

14. Maiden name Elizabeth Gross

15. Birthplace Calvert Co., Md.

16. Informant SARAH Crowdy

Address 622 - 2nd Street - East Port

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 10 1949 (month) (day) (year)

Cemetery or crematory Brewer

Location Annapolis, Maryland

18. Funeral director William Reese

Address 108 Washington Street - Annapolis

19. July 10, 1949 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5, 1949 19 ..... at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5, 1949 19 ..... to July 5, 1949 19 .....

and that I last saw him alive on July 5, 1949 19 .....

Immediate cause of death	DURATION
Cardiac Failure	
Due to Hypertensive Cardio Vascular Disease	1 day
Due to	
Other conditions	

443 93d

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Theodore L. Johnson M.D.

M. D. or other

Address 40 Northwest Street Date signed 7/9/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

RECEIVED
JUL 12 1949
BUREAU F. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06403

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Galesville
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Galesville COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Viola (Middle) (Last) Crowner

4. DATE OF DEATH (Month) July (Day) 29 (Year) 1949

5. SEX Female
6. COLOR OR RACE Col
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH July 9, 1924
9. AGE last birthday 25 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Galesville Md
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Robert Crowner
14. MOTHER'S MAIDEN NAME Elenor Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY No. 214-12-0846
17. INFORMANT Matilda Trusty

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary Tuberculosis — 7 mons

002

Antecedent cause(s)

13b

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. No

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) No
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 14, 1949, to July 29, 1949, that I last saw the deceased alive on July 29, 1949, and that death occurred at 3:05 A m., from the causes and on the date stated above.

SIGNATURE Theodore H. Johnson M.D. (Degree or title) ADDRESS 40 Northwood Street Annapolis, Md. DATE SIGNED July 29 1949

23. BURIAL, ~~CREMATION REMOVAL (Specify)~~ DATE Aug 1. 1949 NAME OF CEMETERY OR CREMATORY Crowners Cem. LOCATION (City, town, or county) Galesville Md (State)

DATE REC'D BY LOCAL REG Aug 1st 1949 REGISTRAR'S SIGNATURE M. Clayton Dep. Reg.
24. FUNERAL DIRECTOR F. A. Hardesty & Son ADDRESS Galesville Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 5 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06404

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:

County: Ann Arundel

City or town: ~~Laurel~~ Rural - near Laurel
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: District Training School

How long in hospital or institution? 26 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. Maryland Washington County: Ann Arundel

City or town: Rural - near Laurel
(If outside city or town limits, write RURAL and give nearest town)

Street No. District Training School
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Michael Doyle

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 2, 1943

8. AGE: Years	Months	Days	If less than one day
5	9		..... hrs. ..... min.

9. Birthplace: La Plata, Maryland
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business: "

FATHER
12. Name: James Doyle
13. Birthplace: Germany

MOTHER
14. Maiden name: Syn Turner
15. Birthplace: Unknown

16. Informant: Bd. Public Welfare - Wash. D.C.

Address

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof: 7-29-49 (month) (day) (year)

Cemetery or crematory: D.T.S. Burial Ground

Location: D.T.S. Laurel

18. Funeral director: D.T.S. Officials

Address: Dist Tr School

19. July 28 1949
(Date rec'd by registrar)

Clara Haslup
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 1949, at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 4 1949, to July 1927 and that I last saw him alive on July 27 1949

Immediate cause of death: Pneumonia, Dilateral, lobular — DURATION: 4 days

Due to: Mental retardation, cerebral palsy, idiocy — life

Due to: Malnutrition — life

Other conditions: 490 / 1.08
(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: Pneumonia, lobular

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: J. A. Alston, M.D.
M. D. or other

Address: D.T.S. Date signed: 7-27-49

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

RECEIVED
AUG 5 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06405

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. A. County Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gambrils
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) ELMER (Middle) (Last) EDELEN

4. DATE OF DEATH (Month) July (Day) 5 (Year) 1949

5. SEX M | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married | 8. DATE OF BIRTH 9/2/1887 | 9. AGE last birthday 61 yrs. | If under 1 year Months. Days | If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer | 10b. KIND OF BUSINESS OR INDUSTRY farm | 11. BIRTHPLACE (State or foreign country) Maryland | 12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME James L. Edelen | 14. MOTHER'S MAIDEN NAME Mary Richards

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ? (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. none | 17. INFORMANT Mrs. Rose Lee Edelen

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Ac. Coronary Thrombosis — instantaneous

420.1 Antecedent cause(s) (b) none.

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 15, 1949, to July 5, 1949, that I last saw the deceased alive on 6/30, 1949, and that death occurred at 6:30 P m., from the causes and on the date stated above.

SIGNATURE Maurice F Klawans, Md (Degree or title) | ADDRESS Annapolis, Md | DATE SIGNED 7/5/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE 7-8-49 | NAME OF CEMETERY OR CREMATORY Trinity Episcopal | LOCATION (City, town, or county) Upper Marlboro, Md (State)

DATE REC'D BY LOCAL REG. July 5, 1949 | REGISTRAR'S SIGNATURE [signature] | 24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md. | ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 7 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

06406

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arnold — LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Deep Creek

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 501-12th St. N.E

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
HARRY	HUFF	EVERLY	July	24	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE Last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	Oct. 24, 1906	42 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life. Ans if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Filling Station Operator	Filling Sta.	Virginia	U.S.A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Arthur Everly	Ora A. Huff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
World War I Nav		Mrs Anna Lucille Everly

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	Sudden
Antecedent cause(s) Diseases or conditions, If any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	unknown
	(c)	

420.1 (1a)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Was in swimming when he had attack

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY m.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John M. Coffey	M.D. Deputy Medical Examiner	Annapolis Md	7-24-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Removal	7-24-49	J. Wm. Lee Sons Co	Washington, D.C.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 24, 1949	W. T. French	J. Wm Lee Sons Co	Washington DC

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06407

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH · COUNTY: Anne Arun del MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: WicomicO
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville, Md. LENGTH OF STAY (in this place): 5 months	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Jesterville, Md.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital, Md.	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Vaughn Eugene Gain es			4. DATE OF DEATH (Month) (Day) (Year): 7/16/49 19	
5. SEX: Male	6. COLOR OR RACE: N egro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: 9-6-1939	9. AGE last birthday: 9 yrs. If under 1 year: Months 10 Days 10 If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY: ———		11. BIRTHPLACE (State or foreign country): Jesterville, Md.	12. CITIZEN OF WHAT COUNTRY? —
13. FATHER'S NAME: Linwood Conway			14. MOTHER'S MAIDEN NAME: Adelaide Gaines	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.		17. INFORMANT: Hospital Records	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Congenital Sp astic Paraphlegia — since birth

351 Antecedent cause(s)

157d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) Microcephalic Idiocy — known to us

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. — since admission

19a. DATE OF OPERATION: ———	19b. MAJOR FINDINGS OF OPERATION: ———	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify): ———	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ———	(CITY OR TOWN) (COUNTY) (STATE): ———
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/12, 1949, to 7/16, 1949, that I last saw the deceased alive on 7/16, 1949, and that death occurred at 5:35 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Jacob Margarten M.D.

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 7/23/49	NAME OF CEMETERY OR CREMATORY: Jesterville Cemetery	LOCATION (City, town, or county) (State): Jesterville Md
DATE REC'D BY LOCAL REG.: 7/20-49	REGISTRAR'S SIGNATURE: E. F. Joyce Reg	24. FUNERAL DIRECTOR: C. G. Messick	ADDRESS: Bivalve, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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Evidence for addtion of #18c shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

FILM No. G 121 SEP -7 1949

06468

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Skidmore; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY A. A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Skidmore, R.F.D. # 2, STREET ADDRESS (If rural give location) Annapolis, Md.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Richard	W.	Galloway.	7	29	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	colored	Married	Feb. 16, 1887	62 yrs.	5	13		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
mechanic		Chesterfield Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Richard Galloway	Elvira Spencer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No			Alverta Galloway

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acidosis

306 Antecedent cause(s)

97 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Malnutrition

(c) Arteriosclerotic Dementia (9/7/49 A.S.)

INTERVAL BETWEEN ONSET AND DEATH: 4 days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
		Skidmore	A A	Md

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 7-21, 1949, to 7-29, 1949, that I last saw the deceased alive on 7-28, 1949, and that death occurred at 2 P.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
A. J. Allen	M D	10 Carroll	8-1-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Aug. 2, 1949	Broadneck Memorial Park	Annapolis	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 2, 1949	W. D. Branch	J. B. Johnson	Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

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Reg. Dist. No. 20

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY a a — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edgewater | LENGTH OF STAY (in this place) 1 month
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY a e
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Edgewater
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) James (Middle) Louis (Last) Garton

4. DATE OF DEATH: (Month) July (Day) 4 (Year) 19 49

5. SEX: M | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single | 8. DATE OF BIRTH: June 2/49 | 9. AGE last birthday: yrs. | If under 1 year: Months 1 Days 2 | If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country): annapolis Maryland | 12. CITIZEN OF WHAT COUNTRY? mary

13. FATHER'S NAME: Charles E Garton | 14. MOTHER'S MAIDEN NAME: Margaret E Summerlin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — | (If yes, give war or dates of service) — | 16. SOCIAL SECURITY NO. — | 17. INFORMANT: Charles E Garton

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Spina Bifida — Interval Between Onset and Death: Congenital

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

7751
1576

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Not operative.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/2, 19 49, to 7/4, 19 49, that I last saw the deceased alive on 7/3, 19 49, and that death occurred at ....m., from the causes and on the date stated above.

SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED
Maurice F Klawans, MD — Annapolis — Md.

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF 7/5/49 | NAME OF CEMETERY OR CREMATORY St Mary's | LOCATION (City, town, or county) annapolis | (State) Md

DATE REC'D BY LOCAL REG. July 5, 1949 | REGISTRAR'S SIGNATURE Edward Collenson | 24. FUNERAL DIRECTOR | ADDRESS
B. L. Hopping & Son

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06410

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH: A.A.

County

City or town Ferndale.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County A.A.

City or town Ferndale
(If outside city or town limits, write RURAL and give nearest town)

Street No. 110 Ferdinand Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Viola May Grable.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M.

6.(b) Name of husband or wife George A.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 10-7-1900

8. AGE: Years	Months	Days	If less than one day
48	9	1	..... hrs. ..... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Henry G. Wentworth
13. Birthplace Md.

MOTHER
14. Maiden name Minnie R. Lynch
15. Birthplace Md.

16. Informant Family
Address Same.

17. B. (Burial, cremation, or removal. Which?) Date thereof 7-12-49. (month) (day) (year)

Cemetery or crematory Glen Haven

Location Glen Burnie

18. Funeral director [illegible]
Address 130 E. Fort Ave.

19. July 12 1949 (Date rec'd by registrar) Ida M. Whitem Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1949, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 15 1949, to July 8 1949 and that I last saw her alive on July 8 1949

Immediate cause of death	DURATION
Cancer uterus and cervix (Carcinoma).	2 yrs.
Due to	
Due to	
171 48a Other conditions Lymphangitis left leg. (Include pregnancy within 3 months of death)	6 mos.

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. L. Ball Jr. M.D. or other

Address Linthicum Date signed 7/8/49

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BUREAU V. S.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06411

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Churchton, Md. LENGTH OF STAY (In this place) Life	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Churchton (Rural)
HOSPITAL OR INSTITUTION OR STREET ADDRESS None	STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED (Type or Print) (First) ALEXANDER (Middle) — (Last) GROSS

4. DATE OF DEATH (Month) July (Day) 31 (Year) 1949

5. SEX Male | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower | 8. DATE OF BIRTH 1879 | 9. AGE last birthday 70 yrs. | If under 1 year Months. Days | If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oysterman | 10b. KIND OF BUSINESS OR INDUSTRY Oyster Tonging | 11. BIRTHPLACE (State or foreign country) Churchton, Md | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Gross | 14. MOTHER'S MAIDEN NAME Elizabeth Scott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. None | 17. INFORMANT Wendell Gross

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
491 Immediate cause	(a) Broncho-Pneumonia (Primary)	6 days
Antecedent cause(s)		
107 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) —	
	(c) —	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION — | 19b. MAJOR FINDINGS OF OPERATION — | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) — | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — | (CITY OR TOWN) — (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) — m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from July 27, 1949, to July 31st, 1949, that I last saw the deceased alive on July 31, 1949, and that death occurred at 2:00 P m., from the causes and on the date stated above.

SIGNATURE R. L. Richardson (Degree or title) M.D. ADDRESS 110 - Day St Annapolis Md. DATE SIGNED 7/31/49

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) | DATE Aug 3, 1949 | NAME OF CEMETERY OR CREMATORY Gross Cem. | LOCATION (City, town, or county) Churchton (State) Md

DATE REC'D BY LOCAL REG. Aug 3- | REGISTRAR'S SIGNATURE J. B. Dent | 24. FUNERAL DIRECTOR F. A. Stardusty & Son ADDRESS Galesville Md

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06412

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH · COUNTY: A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Churchton
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Thomas (Middle) O. (Last) Howes
4. DATE OF DEATH (Month) July (Day) 7 (Year) 1949
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: June 6, 1886
9. AGE last birthday: 63 yrs. If under 1 year: Months 1 Days 1 If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Oysterman
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Churchton
12. CITIZEN OF WHAT COUNTRY? Citizen
13. FATHER'S NAME: John H. Howes
14. MOTHER'S MAIDEN NAME: Mary Tucker
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Naomi Nutwell

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Chronic Lymphatic Leukemia	1 year
204.0 Antecedent cause(s)	(b) Myocarditis Chronic	1 year
74a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis Generalized — unknown

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify):
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1948, to July 7, 1949, that I last saw the deceased alive on July 7, 1949, and that death occurred at 10:10 p.m., from the causes and on the date stated above.

SIGNATURE: George C. Basil (Degree or title) M.D. ADDRESS: Annapolis Md. DATE SIGNED: 7-7-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE: 7/10/49
NAME OF CEMETERY OR CREMATORY: Woodfield Cemetery
LOCATION (City, town, or county): Galesville (State) Md.

DATE REC'D BY LOCAL REG.: July 8, 1949
REGISTRAR'S SIGNATURE: [signature]
24. FUNERAL DIRECTOR: T. A. Hardisty & Son ADDRESS:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06413

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel County MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 1133 W. Franklin Street

3. NAME OF DECEASED (Type or Print) (First) Emma (Middle) (Last) Henderson

4. DATE OF DEATH (Month) July (Day) 3 (Year) 1949

5. SEX Female

6. COLOR OR RACE Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH about 1885

9. AGE last birthday 64 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME unknown to us

14. MOTHER'S MAIDEN NAME unknown to us

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Myocarditis

Antecedent cause(s)

422,2 93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Senile Psychosis

(c)

INTERVAL BETWEEN ONSET AND DEATH known to us since 10/15/41

10/15/41

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) ——

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE) ——

TIME OF INJURY (Month) (Day) (Year) (Hour) m. ——

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? ——

22. I hereby certify that I attended the deceased from October 15, 1941, to July 3, 1949, that I last saw the deceased alive on July 3, 1949, and that death occurred at 3:30 p. m., from the causes and on the date stated above.

SIGNATURE Jacob Moyceisten M.D. (Degree or title) ADDRESS CROWNSVILLE STATE HOSPITAL DATE SIGNED July 4, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 7/6/49 NAME OF CEMETERY OR CREMATORY Mt Auburn Cem LOCATION (City, town, or county) Balto. (State) Md.

DATE REC'D BY LOCAL REG. 7/6/49 REGISTRAR'S SIGNATURE A. W. Hedrick

24. FUNERAL DIRECTOR Mrs Katie R. Williams ADDRESS 323 N Schroeder St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

BG 411

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Deale
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS none

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Deale
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Thomas (Middle) Harry (Last) Henley

4. DATE OF DEATH: (Month) July (Day) 31 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~ (Specify): MARRIED

8. DATE OF BIRTH: Sept 4 1872

9. AGE last birthday: 77 yrs. If under 1 year: Months. If under 24 hrs.: Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: FARMER

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Edward Henley

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)

16. SOCIAL SECURITY No.: NO

17. INFORMANT: Mrs Nannie Henley

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral thrombosis — Interval between onset and death: 2 days.

332 Antecedent cause(s)

838 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) arteriosclerosis, hypertension

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none.

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): no

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): —

(CITY OR TOWN): Deale (COUNTY): A.A. (STATE): Md.

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 29, 1949, to July 31, 1949 that I last saw the deceased alive on July 29, 1949, and that death occurred at 2 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Emil H. Wilson, M.D. ADDRESS: Lothian, Md. DATE SIGNED: 8-1-49.

23. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify) | DATE: Aug 2-1949 | NAME OF CEMETERY OR CREMATORY: St. James | LOCATION (City, town, or county): Gracey (State): Md

DATE REC'D BY LOCAL REG.: Aug. 2 1949 | REGISTRAR'S SIGNATURE: W. B. Dent

24. FUNERAL DIRECTOR: T. A. Standerfer & Son ADDRESS: Galesville Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
AUG 4 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06415

Reg. Dist. No. 25

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY Anne Arundel (Brooklyn) MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Baltimore, MD
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4907 Kramme Ave

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE MD COUNTY A.A.Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Baltimore, MD Brooklyn
STREET ADDRESS (If rural, give location) 4907 Kramme Ave.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Helen	Grace	Hoff	7	28	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months.	Days	If under 24 hrs. Hours	Min.
F	W	Married	12-1-1879	69 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jessie R. McKaig
14. MOTHER'S MAIDEN NAME: Mary McClure

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: Charles H. Hoff, Sr

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	1 month
443 Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterial Hypertension & Sclerosis	5 yrs.
	(c) Chronic Nephritis	5 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1945, to July, 1949, that I last saw the deceased alive on July 28, 1949, and that death occurred at 3:30 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
P. J. Arnold M.D. 4609 Gov. Ritchie Hwy 7-29-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	7-30-49	Western Cemetery	Edmondson Ave. Balto. Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
7/29/49	G. W. Hughes	John F. Denny, Inc	715 Light St. Baltimore-30, Md.

Dr. Grimaldi

1609 Retailer History

10 to 12

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06416

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) One (1) Day
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Churchton
STREET ADDRESS (If rural give location) ---

3. NAME OF DECEASED (Type or Print) (First) Wilbert (Middle) (Last) Holland
4. DATE OF DEATH (Month) 7 / (Day) 20 / (Year) 1949
5. SEX Male
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH 1/9/ 1909
9. AGE last birthday 40 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Orching
10b. KIND OF BUSINESS OR INDUSTRY ---
11. BIRTHPLACE (State or foreign country) Churchton, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME Alexander Holland
14. MOTHER'S MAIDEN NAME Cora Blake
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 219-12-4134
17. INFORMANT Blake Holland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pneumonia, lobar rt lower lobe 1 wk.

490 Antecedent cause(s) (? Organism

108 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 19 July, 1949, to 20 July, 1949, that I last saw the deceased alive on 20 July, 1949, and that death occurred at 7:45 A.m., from the causes and on the date stated above.

SIGNATURE Imeld Hooker, M.D. (Degree or title) ADDRESS 53 Cornhill St. Annapolis, Md. DATE SIGNED 22 July 49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 7/23/49
NAME OF CEMETERY OR CREMATORY Chews Chapel
LOCATION (City, town, or county) (State) Churchton, A.A.Co. Maryland

DATE REC'D BY LOCAL REG. July 23, 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR Mrs Charles E. Hicks & Son ADDRESS 45 Northwest St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 28 1949
BUREAU OF U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06417

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (In this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Annapolis
STREET ADDRESS (If rural, give location) Forest Hill Drive

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Jane (Last) Hopkins

4. DATE OF DEATH: (Month) 7 (Day) 15 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH: 11-13-1880

9. AGE last birthday: 68 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Charles D. Hyde

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: E. Roland Hopkins

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) Cerebral accident	5 days
422.2 Antecedent cause(s)	(b) Cerebral vascular sclerosis	unknown
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Auricular fibrillation	5 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	(d) Chronic myocarditis.	6 years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 26, 1949, to July 14, 1949, that I last saw the deceased alive on July 14, 1949, and that death occurred at 3:50 P. m., from the causes and on the date stated above.

SIGNATURE John M. Claffy (Degree or title) M.D., ADDRESS Annapolis, Md. DATE SIGNED 7-17-49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	7-18-1949	Cedar Bluff	Annapolis, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 18, 1949	[illegible] Branch	John M. Taylor & Son	Annapolis

VS. A15

RECEIVED
JUL 2 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06418

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
MARYLAND
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland
COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
STREET ADDRESS (If rural, give location) 507 First Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Neva	P.	Hopkins	July	17	1949

5. SEX	6. COLOR OR RACE	7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White		Oct. 24, 1894	55 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Housewife	House	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Wm. Laird	Nellie Parks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
		Wm. L. Hopkins

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Coronary Thrombosis	12 days
420.1 Antecedent cause(s) 94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension	6 years
(c) Arteriosclerosis (Moderate)	Several years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from July 5, 1949, to July 17, 1949, that I last saw the deceased alive on July 17, 1949 and that death occurred at 9 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
George C Basil	MD	Annapolis Md	7-19-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	7-20-49	Creole Church Yard.	Creole Somerset Co Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 19, 1949	Wm. L. Hopkins	John M. Taylor, Son	Annapolis Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
JUL 1 1943
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

Bc 06419

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 1½ years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State H ospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY B. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN B altimore City
STREET ADDRESS (If rural, give location) 642 W. H offman St.,

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Belle (Last) Jackson
4. DATE OF DEATH (Month) 7 - (Day) 19 (Year) 1949
5. SEX Female
6. COLOR OR RACE colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Separated
8. DATE OF BIRTH 4/1/94
9. AGE last birthday 55 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - - - - - -
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME ? Marshall
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) - - (If year, give war or dates of service) -
16. SOCIAL SECURITY NO. - - - -
17. INFORMANT Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) H ypertensive heart disease — INTERVAL BETWEEN ONSET AND DEATH: Known to us since admission 10/20/47

443 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) Cerebral arteriosclerosis with psychosis

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION - - - -
19b. MAJOR FINDINGS OF OPERATION - - - - -
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) - - -
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - - -
(CITY OR TOWN) - - - - (COUNTY) - - - (STATE) - - -
TIME OF INJURY (Month) (Day) (Year) (Hour) - - - - - - - - m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? -

22. I hereby certify that I attended the deceased from 10/20, 1947, to 7/19, 1949, that I last saw the deceased alive on 7/19, 1949, and that death occurred at 5:05 P.m., from the causes and on the date stated above.

SIGNATURE Jacob Morgenstern M.D. (Degree or title) ADDRESS Crownsville, Md. DATE SIGNED 7/19/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 7/25/49 NAME OF CEMETERY OR CREMATORY Mt. Calvary LOCATION (City, town, or county) Baltimore, (State) Md.

DATE REC'D BY LOCAL REG. 7/25/49 REGISTRAR'S SIGNATURE A. W. Hedrick

24. FUNERAL DIRECTOR Adolphus Halstead ADDRESS Baltimore, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH Bc

2411 N. Charles Street, Baltimore

06420

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH · COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Balt. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): 3 mos. 24 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): 204 North Bradford Street ✓

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): William Jackson			4. DATE OF DEATH (Month) (Day) (Year): 7/24/49 19		
5. SEX: male	6. COLOR OR RACE: colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: March 11, 1896	9. AGE last birthday: 53 yrs.	If under 1 year: Months. Days; If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer	10b. KIND OF BUSINESS OR INDUSTRY: none		11. BIRTHPLACE (State or foreign country): Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Randolph Jackson			14. MOTHER'S MAIDEN NAME: Martha Murphy		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT: Hospital Records		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Myocard-Degeneration	known
422.1 Antecedent cause(s)	(b) Generalized Arteriosclerosis	since admission
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/31/49, 19....., to 7/24/49, 19....., that I last saw the deceased alive on 7/24/49, 19....., and that death occurred at 5:15 A.M. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Thorpenstein M.D.		Crownsville, Md.	5/24/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	7/28/49	U.S. Baltimore National		Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
7/27/49	A. W. Hedwich	Rayner Sanders	1412 E. Preston St

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06421

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): 17 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): 1318 Division St. Baltimore, Md.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Clarence Johnson			4. DATE OF DEATH (Month) (Day) (Year): 7 16 1949	
5. SEX: Male	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Separated	8. DATE OF BIRTH: ~~Not known~~ about 1894	9. AGE last birthday: 55 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer	10b. KIND OF BUSINESS OR INDUSTRY: none	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME: George Johnson		14. MOTHER'S MAIDEN NAME: Mam ie Walker		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unknown — (If year, give war or dates of service)	16. SOCIAL SECURITY NO.: unknown	17. INFORMANT: Hospital Records		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Exhaustion, Carcinoma of the stomach.	known to us
151 Antecedent cause(s)		since 3/28 49
46b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	
II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.	Dementia Praecox	known to us

19a. DATE OF OPERATION: 3/28/49	19b. MAJOR FINDINGS OF OPERATION: Carcinoma of the stomach with pyloric obstruction and liver metastasis (since admission 1932)	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from October, 1941, to 7/16/49, 1949, that I last saw the deceased alive on 7/16, 1949, and that death occurred at 6:00 A.m., from the causes and on the date stated above.

SIGNATURE: Jacob Marcuston M.D. (Degree or title) — ADDRESS — DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE: July 19, 1949	NAME OF CEMETERY OR CREMATORY: Mt Auburn	LOCATION (City, town, or county): Baltimore (State): Md.
DATE REC'D BY LOCAL REG.: July 16. 49	REGISTRAR'S SIGNATURE: E. F. Joya Local Reg	24. FUNERAL DIRECTOR: Mrs Samuel T. Hemsly	ADDRESS: 578 W. Biddle St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 19 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06422

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH · COUNTY: Anne Arunde 1 MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: A. A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (In this place): 22 hours	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): 26 Northwest Street

3. NAME OF DECEASED (Type or Print)	(First) Reba	(Middle) R.	(Last) Johnson	4. DATE OF DEATH	(Month) July (Day) 3 (Year) 1949
5. SEX: Female	6. COLOR OR RACE: Ne gro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: March 6, 1910	9. AGE last birthday: 39 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic	10b. KIND OF BUSINESS OR INDUSTRY: -------	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME: Aaron Johnson		14. MOTHER'S MAIDEN NAME: Martha Johnson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If year, give war or dates of service): -----	16. SOCIAL SECURITY NO.: 214-05-1319	17. INFORMANT: Hospital Records		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Exhaustion	Known to us 1 day.
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Schizophrenia Catatonic Type	
	(c) ----------	

300.2
84b

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. ----------

19a. DATE OF OPERATION: -------	19b. MAJOR FINDINGS OF OPERATION: ----------	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify): -----	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): -------	(CITY OR TOWN) (COUNTY) (STATE): ----------
TIME OF INJURY (Month) (Day) (Year) (Hour): ------- m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? ----------

22. I hereby certify that I attended the deceased from July 2, 1949, to July 3, 1949, that I last saw the deceased alive on July 3, 1949, and that death occurred at 1:10 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Shorecister	M.D.	CROWNSVILLE STATE HOSPITAL	July 4, 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 7/6/1949	NAME OF CEMETERY OR CREMATORY: Brewer Hill Cemetery	LOCATION (City, town, or county) (State): West St. Annapolis, Md.
DATE REC'D BY LOCAL REG.: July 6, 1949	REGISTRAR'S SIGNATURE: E. F. Joyce Local Reg.	24. FUNERAL DIRECTOR: Mrs. Charles E. Hicks & Son	ADDRESS: 45 Northwest St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 9 1949
BUREAU V. S.

06423

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 20

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN near Davidsonville
LENGTH OF STAY (in this place) 2 hrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pawtuxent River

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Dist. of Columbia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 937 - H. St., N.W

3. NAME OF DECEASED (Type or Print) (First) Ernest (Middle) Albert (Last) Jones
4. DATE OF DEATH (Month) July (Day) 5 (Year) 1949
5. SEX male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH Feby 13, 1891
9. AGE last birthday 58 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman
10b. KIND OF BUSINESS OR INDUSTRY Bay Boats
11. BIRTHPLACE (State or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Abraham L. Jones
14. MOTHER'S MAIDEN NAME Callie Corn
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) 1922-1925
16. SOCIAL SECURITY NO.
17. INFORMANT Glover T. Jones

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Drowning

929.8 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) accidental

183

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Pawtuxent (CITY OR TOWN) near Davidsonville (COUNTY) A.A. (STATE) Md
TIME OF INJURY (Month) July (Day) 5 (Year) 1949 (Hour) 7 P.M.
INJURY OCCURRED While at work ☐ Not while at work ☑
HOW DID INJURY OCCUR? Fell down embankment into River

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Klaffey M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 7/6/49

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
DATE THEREOF JULY 8-1949
NAME OF CEMETERY OR CREMATORY Woodfields Cem
LOCATION (City, town, or county) Galesville (State) Md
DATE REC'D BY LOCAL REG. 7/8/49
REGISTRAR'S SIGNATURE W.N. Clayton Dep Local Reg
24. FUNERAL DIRECTOR F.A. Hardesty & Son Galesville ADDRESS Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JUL 12 1949
BUREAU F. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Bc 06424

Reg. Dist. No. 27

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ft George G. Meade, Md — LENGTH OF STAY (in this place): 1 year
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Station Hospital Ft G G Meade

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural give location): 536 North Carrollton Ave

3. NAME OF DECEASED (Type or Print): (First) WILLIAM (Middle) NATHANIEL (Last) JONES

4. DATE OF DEATH: (Month) July (Day) 10 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 31 Dec 1928

9. AGE last birthday: 20 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier

10b. KIND OF BUSINESS OR INDUSTRY: U. S. Army

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY: United State

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): 29 Aug 47

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Service Record U. S. Army

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) D. O. A. GUN SHOT WOUND BRAIN RIGHT

919.7

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

184

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION: None

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Guard House (CITY OR TOWN): Ft G G Meade (COUNTY): Anne Arundel (STATE): Maryland

TIME OF INJURY (Month) (Day) (Year) (Hour): July 10 1949 2230 m.

INJURY OCCURRED While at Work ☒ Not While At work ☐

HOW DID INJURY OCCUR? Accidently shot by man cleaning gun

PRONOUNCED DEAD,

22. I hereby certify that I attended the deceased from 10 July 1949, to 10 July, 1949 that I last saw the deceased alive on ....., 19....., and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE: William R. Post (Degree or title): MD ADDRESS: Station Hospital Ft Meade, Md DATE SIGNED: 10 July 49

23. BURIAL, CREMATION / REMOVAL (Specify): Removal — DATE THEREOF: 11 July 1949 — NAME OF CEMETERY OR CREMATORY: National Cemetery — LOCATION (City, town, or county): Baltimore — (State): Md

DATE REC'D BY LOCAL REG.: 11 July 1949 — REGISTRAR'S SIGNATURE: E.K. BURNSIDE CAPT., MSC

24. FUNERAL DIRECTOR: Chas G Cooper — ADDRESS: 512 N. Carrollton Ave. Baltimore, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06425

Reg. Dist. No. 4/

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundle; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Agnes (Middle) (Last) Keddie

4. DATE OF DEATH: (Month) (Day) (Year) July 2, 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Sept. 10, 1865

9. AGE last birthday: 83 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Lochgelly, Scotland

12. CITIZEN OF WHAT COUNTRY? Scotland

13. FATHER'S NAME: John Keddie

14. MOTHER'S MAIDEN NAME: Margaret Dick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: grandniece

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) heart failure — 1½ years

420.1 Antecedent cause(s)

94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) coronary heart disease

(c) gen. arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 23rd, 1949, to July 2nd, 1949, that I last saw the deceased alive on July 2nd, 1949, and that death occurred at 3:15 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Edith Roller, M.D. 42 State Circle Annapolis, Md. July 2nd 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE: July 5, 1949 | NAME OF CEMETERY OR CREMATORY: Prospect Hill Cemetery | LOCATION (City, town, or county) (State): Towson, Maryland

DATE REC'D BY LOCAL REG.: 7/5/49 | REGISTRAR'S SIGNATURE: Wm. J. French | 24. FUNERAL DIRECTOR ADDRESS: John Burns' Sons, Towson, Md.

RECEIVED
JUL 7 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06426

CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY A.A. Co
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Morris Hill
LENGTH OF STAY (in this place) MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md COUNTY AA Co
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Morris Hill
STREET ADDRESS (If rural, give location) R.F.D #9

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Joseph	F	Knott	July	3	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months.	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	Oct 24, 1863	86 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Self	Md	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Knott	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
—	—	—	Janie Knott

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cardio-Vascular Disease	6 mos.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arteria-Sclerosis	10 yr.
	(c) Cystitis — Prostatic Enlargement	1 yr.

422.1
938

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from Jan, 1947, to July 3, 1949, that I last saw the deceased alive on July 3, 1949, and that death occurred at 5 P. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Chas. L. Ball	M.D	Linthicum	7/3/49

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	July 7, 1949	Cedar Hill	Annapolis Blvd Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
7-5-49	A.W. Ardrey	John F. Denny Inc	715 Light

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06427

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cedar Crest Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severna Park
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Lottie (Middle) V (Last) Lyles

4. DATE OF DEATH: (Month) July (Day) 28 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Oct 10 1883

9. AGE last birthday: 65 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Carter

14. MOTHER'S MAIDEN NAME: Mary Carter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) N (If year, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT: Otis M Groves, 2020 N Wolfe St

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 **Immediate cause** (a) Cerebral Hemorrhage — Interval between onset and death: 3 days

Antecedent cause(s)

830 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertension — 1 year 6 days

(c) Hemiplegia — 1 y - 6 days

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) No — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 21, 1949, to July 28, 1949, that I last saw the deceased alive on 7/28, 1949, and that death occurred at 3 20 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

Gustave A. Pardenwerth M.D. — 5-Fruitland S.E. Glen Burnie, Md. — 7/29/49

23. BURIAL, CREMATION, REMOVAL (Specify): Buried — DATE: 7/30/49 — NAME OF CEMETERY OR CREMATORY: Woodlawn — LOCATION (City, town, or county): Woodlawn — (State): Md

DATE REC'D BY LOCAL REG. 7/29/49 — REGISTRAR'S SIGNATURE: A W. Hedrick — 24. FUNERAL DIRECTOR: Hilbourn Co Inc — ADDRESS: 1211 E Fayette St

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06428

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place): 15 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S.Naval Hospital, Annapolis

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural, give location): - - - - - - - - -

3. NAME OF DECEASED (Type or Print): (First) James (Middle) (none) (Last) MC CORMACK

4. DATE OF DEATH: (Month) July. (Day) 19 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White-US

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 4-21-1876

9. AGE last birthday: 73 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner

10b. KIND OF BUSINESS OR INDUSTRY: USN

11. BIRTHPLACE (State or foreign country): Connecticut

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If year, give war or dates of service): Retired

16. SOCIAL SECURITY NO.:

17. INFORMANT: Official Records, USN

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Pneumonia, Lobar, n.e.c., Right Lower and Middle Lobes, Organism Undetermined	3 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Generalized Arteriosclerosis	20 years
	(c)	

450.0
108

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-9-, 19 49, to 7-19, 19 49, that I last saw the deceased alive on 7-19, 19 49, and that death occurred at 1:45 P m., from the causes and on the date stated above.

SIGNATURE: O.H. Thompson Jr.
(Degree or title): LTJG., MC, USNR
ADDRESS: U.S.Naval Hospital, Annapolis, Maryland
DATE SIGNED: 7-19-49

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify)
DATE: July 21, 49
NAME OF CEMETERY OR CREMATORY: St. Annes Annapolis
LOCATION (City, town, or county) (State): Annapolis, Md.

DATE REC'D BY LOCAL REG.: July 21, 1949
REGISTRAR'S SIGNATURE:
24. FUNERAL DIRECTOR: John M. Taylor & Son
ADDRESS: Annapolis, Md.

RECEIVED
JUL 20 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06429

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn Pk; LENGTH OF STAY (In this place) 26 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pumphrey Brooklyn Pk; STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) William (Middle) H (Last) Norfolk

4. DATE OF DEATH: (Month) July (Day) 11 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Dec 19 1869

9. AGE last birthday: 79 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer

10b. KIND OF BUSINESS OR INDUSTRY: B&ORR

11. BIRTHPLACE (State or foreign country): Balto

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: L Norfolk

14. MOTHER'S MAIDEN NAME: Dont know

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Edward A. Norfolk

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Uraemia. — Interval Between Onset and Death: 2 months

592 / 1318 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic nephritis

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: none

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): none

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1948, 19..., to July 11th, 1949, that I last saw the deceased alive on July 11, 1949 and that death occurred at 4.20P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Denis J. Mc Gratty M.D. ADDRESS 1E Randall St Balto 20. DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: July 14/49 — NAME OF CEMETERY OR CREMATORY: Bethel Hist — LOCATION (City, town, or county) (State): Anne Arundel Co Md

DATE REC'D BY LOCAL REG. 7/14/49 — REGISTRAR'S SIGNATURE C. W. Hedges — 24. FUNERAL DIRECTOR C. H. Ward & Evans — ADDRESS 1400 Lombard

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

06430

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Simms Crossing – Parole | LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Simms Crossing – Parole

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Simms Crossing – Parole near Annap.
STREET ADDRESS (If rural, give location) Simms Crossing – Parole near Annapolis

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Clarence	Alfred	Parker	July	15	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	Colored	Single	12/ 22/ 1932	16 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Student	None	Baltimore, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Walton Parker	Evelyn Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No		Evelyn Jackson Parker

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Drowning

850.8 / 172 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Accidental

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office, field, etc.) Meets Creek (CITY OR TOWN) West Annapolis (COUNTY) A. A. (STATE) Md
TIME OF INJURY (Month) July (Day) 15 (Year) 1949 (Hour) 1.55 p.m.
INJURY OCCURRED While at work ☐ Not while at work ☑
HOW DID INJURY OCCUR? Over-turned boat (Could not swim)

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
John M. Raffy M.D. Deputy Medical Examiner Annapolis Maryland 7-16-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	July 17/1949	Carpenters Hill Cemetery	Round Bay A.A.Co.Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
July 17, 1949	[signature]	Mrs Charles E. Hicks & Son	45 Northwest St.

VS. A15A

RECEIVED
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

06432

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Simms Crossing – Parole
LENGTH OF STAY (in this place): Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Simms Crossing – Parole

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Simms Crossing– Parole near Annapolis
STREET ADDRESS (If rural, give location): Simms Crossing– Parole near Annapolis

3. NAME OF DECEASED (Type or Print): (First) James (Middle) Walter (Last) Parker

4. DATE OF DEATH: (Month) July (Day) 15 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: 5/ 15/ 1934

9. AGE last birthday: 15 yrs. — If under 1 year: Months — Days — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Walton Parker

14. MOTHER'S MAIDEN NAME: Evelyn Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Evelyn Jackson Parker

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Drowning

850.8 / 172 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Accidental

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office building) OF INJURY: Weems Creek — (CITY OR TOWN): West Annapolis — (COUNTY): A.A. — (STATE): Md.

TIME OF INJURY: (Month) July (Day) 15 (Year) 1949 (Hour) 2:00 p.m.

INJURY OCCURRED: While at work ☐ Not while at work ☑

HOW DID INJURY OCCUR? boat capsized - (could not swim)

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: John M. Cobb — (Degree or title): M.D. Deputy Medical Examiner — ADDRESS: Annapolis Md — DATE SIGNED: 7-16-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: July 17, 1949 — NAME OF CEMETERY OR CREMATORY: Carpenter's Hill Cemetery — LOCATION (City, town, or county) (State): Round Bay, A.A.Co. Md.

DATE REC'D BY LOCAL REG.: July 17, 1949 — REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR — ADDRESS: Mrs Charles E. Hicks & Son 45 Northwest St.

RECEIVED
JUL 20 1949
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

06431

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (in this place): 8 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Worcester
CITY (If outside corporata limits, writa RURAL and give nearest town) OR TOWN: Berlin
STREET ADDRESS (If rural, give location): Flower Street (number unknown)

3. NAME OF DECEASED (Typa or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year) 19
Janie	Pratt	Pennewell	7/29/49		

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH (Month) (Day) (Year)	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
female	colored	married	~~about~~ not known	53 yrs.				

10a. USUAL OCCUPATION (Give kind of work dona during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housework	none	Maryland	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
L. Warren	not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
*****	*******	Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause (a)	Schizophrenia, Paranoid Type	known since admission
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)		
(c)		

300.3
84b

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
*****	*******	Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
**********	**********			

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
********** m.	**********	*******

22. I hereby certify that I attended the deceased from 7/30/41, 19....., to 7/29/49, 19....., that I last saw the deceased alive on 7/29/49, 19....., and that death occurred at 1:15 A.M. m., from the causes and on the date stated above.

SIGNATURE: Jack Montgomery M.D. (Degree or title) — ADDRESS: Crownsville, Md. — DATE SIGNED: 7/29/49

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	8/2/49		Berlin	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8/1/49	Alice Hedrick Dep	Lottie Gross	1408 Ashland Ave

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06433 22

Reg. Dist. No.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Laurel R. F. D
LENGTH OF STAY (in this place): 38 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md
COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Laurel R. F. D.
STREET ADDRESS (If rural, give location): Fort Meade Road

3. NAME OF DECEASED (Type or Print): (First) Pearl (Middle) Evelyn (Last) Phillips

4. DATE OF DEATH: (Month) July (Day) 30 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: July 4 1911

9. AGE last birthday: 38 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Household Wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Anne Arundel Co. Md

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Franklin Morgan

14. MOTHER'S MAIDEN NAME: Edyn Ruffon.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no

(If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary Edema — Interval Between Onset and Death: 3 hrs.

443 Antecedent cause(s)

30g Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Chr. Myocarditis

(c) Chr. Nephritis Hypertension — 5 yr.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Uncs.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 7, 1949, to July 30, 1949, that I last saw the deceased alive on July 30, 1949, and that death occurred at 2:30 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): B P Warren — ADDRESS: 305 Prairie Dirge St. Laurel, Md — DATE SIGNED:

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Aug 2 1949 — NAME OF CEMETERY OR CREMATORY: Bacons — LOCATION (City, town, or county) (State): Anne Arundel Co Md

DATE REC'D BY LOCAL REG. Aug 1-49 — REGISTRAR'S SIGNATURE: Clara Hadley

24. FUNERAL DIRECTOR — ADDRESS: Ridgely Selby Laurel Md

RECEIVED
AUG 5 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

06434

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (In this place) Dead on arrival
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Virginia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Danville
STREET ADDRESS (If rural, give location) 316 Bellrose Street

3. NAME OF DECEASED (Type or Print) (First) Mattie (Middle) Catherine (Last) Pickeral
4. DATE OF DEATH (Month) July (Day) 7 (Year) 1949
5. SEX female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widow
8. DATE OF BIRTH June 23, 1874
9. AGE last birthday 75 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House keeper
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME John W. Tate
14. MOTHER'S MAIDEN NAME Cora Jackson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Percy E. Taylor

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	unknown
	(c)	

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffy M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 7/7/49

23. ~~BURIAL, CREMATION~~ REMOVAL (Specify) DATE THEREOF 7/9/1949 NAME OF CEMETERY OR CREMATORY ~~Richmond Cem.~~ LOCATION (City, town, or county) Richmond (State) Va

DATE REC'D BY LOCAL REG. July 7, 1949 REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR D. A. Hardesty ADDRESS Galesville Md

FOREST LAWN CEM. RICHMOND. VA.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JUL 9 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06435

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place) 23 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS 74 Washington St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; STREET ADDRESS (If rural, give location) 74 Washington St.

3. NAME OF DECEASED (Type or Print): (First) Hattie (Middle) (Last) Pinkney

4. DATE OF DEATH: (Month) July (Day) 24 (Year) 1949

5. SEX: female

6. COLOR OR RACE: negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: Sept 6 1884

9. AGE last birthday: 64 yrs. If under 1 year: Months; If under 24 hrs.: Days; Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Annapolis, Md.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Richard Pinkney

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Apoplexy	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive Cardio Vascular Disease	3 days
	(c)	

443

93d

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): NO

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/22/49, 19....., to 7/24/49, 19....., that I last saw the deceased alive on 7/24/49, 19....., and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE Theodore A. Johnson (Degree or title) M.D. ADDRESS 40 Northwest Street DATE SIGNED 7/21/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial DATE THEREOF July 27 1949 NAME OF CEMETERY OR CREMATORY Brewer Hill LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. July 27, 1949 REGISTRAR'S SIGNATURE [illegible]

24. FUNERAL DIRECTOR William Leese II ADDRESS 108 Washington Annapolis, Md.

RECEIVED
JUL 0[illegible] 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH Bc 06436

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Anne Arundel; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville; LENGTH OF STAY (in this place): 27 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Balti. City; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore; STREET ADDRESS (If rural, give location): 2226 Madison Avenue ✓

3. NAME OF DECEASED (Type or Print): (First) John (Middle) (Last) Queen

4. DATE OF DEATH: (Month) 7/5/49 (Day) (Year) 19

5. SEX: male

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married

8. DATE OF BIRTH: 12/4/82

9. AGE last birthday: 66 yrs. If under 1 year Mos. If under 24 hrs. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Queen

14. MOTHER'S MAIDEN NAME: Annie Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Miliary Tuberculosis of Lungs — Interval between onset and death: known since 6/9/49

002 Antecedent cause(s)

30b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) General Paresis — known since admission

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/8/49, 19....., to 7/5/49, 19....., that I last saw the deceased alive on 7/5/49, 19....., and that death occurred at 3:50 P.M., from the causes and on the date stated above.

SIGNATURE Jacob Houpt (Degree or title) M.D. ADDRESS Crownsville, Maryland DATE SIGNED 7/5/49

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) DATE 7/9/49 NAME OF CEMETERY ~~OR CREMATORY~~ Hospital LOCATION (City, town, or county) Crownsville Md (State)

DATE RECD BY LOCAL REGR 7/9/49 REGISTRAR'S SIGNATURE E. Joyce Local

24. FUNERAL DIRECTOR Dept Hospital ADDRESS Crownsville Md

RECEIVED
JUL 11 1949
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH 06437

1. PLACE OF DEATH

County Anne Arundel Registration Dist. No. 23.

Village or City Glen Burnie. No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Charlotte E. Riego. If U. S. Veteran, specify WAR

(a) Residence: No. 117 Central Ave. Glen Burnie, Md. Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female.	White	Widowed.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Raymond Riego.

6. DATE OF BIRTH (month, day, and year) July 15, 1882.

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	11	19	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Nurse. Retired Nursing

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. House work

10. Date deceased last worked at this occupation (month and year) 1946

11. Total time (years) spent in this occupation Very few years

12. BIRTHPLACE (city or town) (State or country) England.

FATHER

13. NAME Thomas Woodfall

14. BIRTHPLACE (city or town) (State or country) England.

MOTHER

15. MAIDEN NAME Emma Ann Coombs

16. BIRTHPLACE (city or town) (State or country) England.

17. INFORMANT Mrs. Darcy Lord.

(Address) 117 Central Ave. Glen Burnie.

18. BURIAL, CREMATION, OR REMOVAL Place Cedar Hill Cem. Date July 6, 1949.

19. UNDERTAKER John O. Mitchell & Sons, Inc.

(Address) 1900 Eutaw Place, Balto. Md.

20. FILED 7-5-49, 19 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH July (Month) 4 (Day), 1949 (Year)

22. I HEREBY CERTIFY, That I attended deceased from August, 1948, to July 4, 1949.

I last saw h-er alive on July 4, 1949; death is said to have occurred on the date stated above, at 2 P. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Cardio - Vascular Disease. — Date of onset 1946

Other Contributory Causes of Importance:

Oedema of the Lungs

422.1

93d.

Name of operation None Date of

What test confirmed diagnosis? Symptoms Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) James S. Billingsley M. D.

(Address) 108 Central Ave. Glen Burnie, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a **clerk**.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

06438

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Ann. Arundel. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bay Ridge Md | LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 146. 11th St N.E. Washington. D C
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) MARGARET (Middle) V. (Last) Riley

4. DATE OF DEATH: (Month) July (Day) 28 (Year) 1949

5. SEX: Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single | 8. DATE OF BIRTH: Oct 4 1871 | 9. AGE last birthday: 77 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired | 10b. KIND OF BUSINESS OR INDUSTRY: Gov. Clerk | 11. BIRTHPLACE (State or foreign country): Washington DC | 12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: William T. Riley | 14. MOTHER'S MAIDEN NAME: Jane Bell Curran

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT: Miss Mary F. Riley (Sister)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
422.2 Immediate cause	(a) Pulmonary Edema	1/2 hours
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Chronic Myocarditis	2 yrs.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 5, 1949, to July 28, 1949, that I last saw the deceased alive on July 28, 1949, and that death occurred at 6.15 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

Dr. W. E. Cole | 6014 York Rd. Balto. 12, Md | July 28, 49

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE THEREOF 8-1-49 | NAME OF CEMETERY OR CREMATORY Congressional | LOCATION (City, town, or county) Washington | (State) DC

DATE REC'D BY LOCAL REG. July 28, 1949 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR J. W. Lee Sons Co | ADDRESS Wash. D.C.

RECEIVED
JUL 30 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

06439

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Beale — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Herring Bay

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia — COUNTY — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 1512 Crittenden N.W.

3. NAME OF DECEASED (Type or Print): (First) GEORGE (Middle) CHAS. (Last) SCHEUCH
4. DATE OF DEATH: (Month) July (Day) 24 (Year) 1949
5. SEX: male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Feby 26, 1894
9. AGE last birthday: 55 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mech Engineer
10b. KIND OF BUSINESS OR INDUSTRY: Potomac E. Co
11. BIRTHPLACE (State or foreign country): District of Columbia
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: Charles Daniel Scheuch
14. MOTHER'S MAIDEN NAME: Kate Nass
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW I
16. SOCIAL SECURITY No.:
17. INFORMANT: Charles D. Scheuch

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Drowning — INTERVAL BETWEEN ONSET AND DEATH: Sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Accidental

(c)

927.8
183

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Trying to rescue granddaughter

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Herring Bay — (CITY OR TOWN): Beale — (COUNTY): A.A. — (STATE): Md

TIME OF INJURY (Month) (Day) (Year) (Hour): July 24 1949 4:20 p.m. — INJURY OCCURRED While at work ☐ Not while at work ☑ — HOW DID INJURY OCCUR? Drowned trying to save child

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: John M. Claffey — (Degree or title): M.D., Deputy Medical Examiner — ADDRESS: Annapolis Md — DATE SIGNED: 7-25-49

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE THEREOF: July 27-49 — NAME OF CEMETERY OR CREMATORY: Glenwood Cem — LOCATION (City, town, or county): Wash. D.C. — (State)

DATE REC'D BY LOCAL REGISTRAR: July - 25 - 49 — REGISTRAR'S SIGNATURE: I. B. Dent

24. FUNERAL DIRECTOR: H. S. Hines. — ADDRESS

VS. A15A

Georgia 0115

RECEIVED
JUL 27 1949
BUREAU V. S.

06440

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 26

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Deale
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS County Wharf.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 4406 - 15th St. N.E.
STREET ADDRESS (If rural, give location) Washington

3. NAME OF DECEASED (Type or Print) (First) Penny (Middle) Augusta (Last) SCHEUCH

4. DATE OF DEATH (Month) July (Day) 24 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) —
8. DATE OF BIRTH Oct. 2, 1944
9. AGE last birthday 4 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) District of Columbia
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME Chas. Daniel Scheuch
14. MOTHER'S MAIDEN NAME Dorothea A. Kuntz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT Chas. Daniel Scheuch

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Drowning	sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Accidental	
	(c)	

8508
172

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Herring Bay near (CITY OR TOWN) Deale (COUNTY) A-A (STATE) Md
TIME OF INJURY (Month) July (Day) 24 (Year) 1949 (Hour) 4:20 p.m.
INJURY OCCURRED While at work ☐ Not while at work ☑
HOW DID INJURY OCCUR? Fell out of boat in Herring Bay

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Cliffey, M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis, Md. DATE SIGNED 7-24-49

23. BURIAL, CREMATION REMOVAL (Specify) Removal
DATE THEREOF 7/27/49
NAME OF CEMETERY OR CREMATORY Glenwood Ceme
LOCATION (City, town, or county) Wash. D.C. (State) July 27

DATE REC'D BY LOCAL REG. July - 24 - 49
REGISTRAR'S SIGNATURE J. B. Dent
24. FUNERAL DIRECTOR S. H. Hines Co. Washington ADDRESS D.C.

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JUL 27 1949
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06441

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Anne Arundel

City or town Green Haven

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

.....

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Green Haven

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Martha Alva Seidler

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Adam Seidler

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 27 1901

8. AGE: Years 47 | Months 10 | Days 28 | If less than one day ..... hrs. ..... min.

9. Birthplace: Applegarth Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: John A Brannock

13. Birthplace

MOTHER

14. Maiden name: Martha Dean

15. Birthplace

16. Informant: John Brannock

Address: Rivera Beach

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/28/49 (month) (day) (year)

Cemetery or crematory: Glen Haven

Location: Glen Burnie Md

18. Funeral director: William Cook Inc

Address: 1217 St Paul St

19. 7/27 (Date rec'd by registrar) 1949 A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1949 at 10:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 July 1949, to 25 July 1949 and that I last saw her alive on 25 July 1949

Immediate cause of death: Cancer of the urinary bladder.

Due to .....

Due to .....

Other conditions none

181

52b

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Randall M. McLaughlin M. D. or other

Address Mountain Rd Pasadena Md Date signed July 31 49

VS A15

(I) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06442

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:

County: Anne Arundel Co

City or town: Rural - Lothian, Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1525 McCullough St.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3. (a) FULL NAME: Horace Mann Singleton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 20 1924

8. AGE: Years: 24 Months: 11 Days: 0 If less than one day ..... hrs. ..... min.

9. Birthplace: Anne Arundel Co
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Thomas H Singleton
13. Birthplace: Baltimore, Md

MOTHER
14. Maiden name: Sarah Pratt
15. Birthplace: Anne Arundel Co

16. Informant: Mary C Johnson
Address: Lothian, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 15 1949 (month) (day) (year)

Cemetery or crematory: National Cem.

Location: Baltimore, Md

18. Funeral director: J. B. Johnson
Address: Annapolis

19. July 13 1949 (Date rec'd by registrar) M. R. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 July 1949, at 5 50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 June 1949, to 12 July 1949 and that I last saw him alive on 10 July 1949

Immediate cause of death	DURATION
Cachexia	
Bilat pulmonary tuberculosis	Unk
Due to	
Due to	
002 / 13A Other conditions: Chr Schizophrenia	4 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Robert B. Sasser M. D. ~~or other~~

Address: Upper Marlboro, Md Date signed: 12 July 49

RECEIVED
JUL 19 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

06443

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (In this place) 3 mos
HOSPITAL OR INSTITUTION OR STREET ADDRESS Severn River at St. Helena Island

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gaithersburg
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) MELVIN (Middle) (Last) SMITH

4. DATE OF DEATH (Month) July (Day) 27 (Year) 1949

5. SEX MALE

6. COLOR OR RACE NEGRO

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Aug. 27, 1919

9. AGE last birthday 29 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook

10b. KIND OF BUSINESS OR INDUSTRY Club House

11. BIRTHPLACE (State or foreign country) District of Columbia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME Augustine Bemberg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Robert Snowden

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

850.8 Immediate cause (a) Drowning

172 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Accidental

(c)

INTERVAL BETWEEN ONSET AND DEATH: sudden

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Severn River near (CITY OR TOWN) Crownsville (COUNTY) A. A. (STATE) Md.

TIME OF INJURY (Month) July (Day) 27 (Year) 1949 (Hour) 6.30 p.m.

INJURY OCCURRED While at work ☐ Not while at work ☑

HOW DID INJURY OCCUR? Fell off boat at Wharf when landing

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffy, M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis, Md. DATE SIGNED 7-28-49

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF July 31 1949 NAME OF CEMETERY OR CREMATORY Emory Grove LOCATION (City, town, or county) Gaithersburg (State) Md.

DATE REC'D BY LOCAL REG. July 28, 1949 REGISTRAR'S SIGNATURE E. F. Joyce Local Reg.

24. FUNERAL DIRECTOR J. B. Johnson ADDRESS Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JUL 30 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06444

CERTIFICATE OF DEATH

Reg. Dist. No. 6021

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: ANNE ARUNDEL — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place): 1 week
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Caroline
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Denton
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) WALTER (Middle) (Last) SPARKLIN

4. DATE OF DEATH: (Month) 7 (Day) 23 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: Jan 8, 1864

9. AGE last birthday: 85 yrs. — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerical

10b. KIND OF BUSINESS OR INDUSTRY: insurance

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Daniel Sparklin

14. MOTHER'S MAIDEN NAME: Alisha Cochran

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If year, give war or dates of service):

16. SOCIAL SECURITY No.:

17. INFORMANT: Mrs. Jas. Clark

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pyelonephritis — Interval Between Onset and Death: 1 wk.

331 Antecedent cause(s)

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Cerebral hemorrhage with hemiplegia — 3 wks.

(c) Senility — 1 yr.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-18-, 1949, to 7-23-, 1949, that I last saw the deceased alive on 7-23-, 1949, and that death occurred at 7 20 p.m., from the causes and on the date stated above.

SIGNATURE: James R. Martin M.D.
(Degree or title)
ADDRESS:
DATE SIGNED: 7-23-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: July 26, 1949
NAME OF CEMETERY OR CREMATORY: Denton
LOCATION (City, town, or county) (State): Denton, Caroline Md.

DATE REC'D BY LOCAL REG.: 7/25/49
REGISTRAR'S SIGNATURE: Wm. T. French

24. FUNERAL DIRECTOR: J. Virgil Moore
ADDRESS: Denton, Md.

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JUL 27 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06445

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport, Md. | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 424 6th Street

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY A. A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport, Md.
STREET ADDRESS (If rural give location) 424 Sixth St.

3. NAME OF DECEASED (Type or Print): (First) Rachael (Middle) E. (Last) Stewart

4. DATE OF DEATH: (Month) July (Day) 20 (Year) 1949

5. SEX: F | 6. COLOR OR RACE: W | 7. SINGLE, MARRIED, WIDOWED, ~~DIVORCED~~, (Specify): | 8. DATE OF BIRTH: 10/4/1878 | 9. AGE last birthday: 70 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurse | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country): Annapolis, Md | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Baker | 14. MOTHER'S MAIDEN NAME: Estella Tydings

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT: Mrs William H. Boteter

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) Myocarditis Chr. & Myocardial Insufficiency	6 months
422.1 Antecedent cause(s)	(b) Arteriosclerosis Generalized	unknown
50 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Chr. Interstitial Nephritis	6 months
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Carcinoma Breast (Rt) localized	3 months

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jun, 1949, to July 20, 1949, that I last saw the deceased alive on July 20, 1949, and that death occurred at 9 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
George C Boteler M.D. | Annapolis Md | 7-21-49

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE 7/23/49 | NAME OF CEMETERY OR CREMATORY Cedar Bluff | LOCATION (City, town, or county) Annapolis | (State) Md

DATE REC'D BY LOCAL REG. July 22, 1949 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR John M. Taylor & Son | ADDRESS Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 25 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06446

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 114 Market St.

3. NAME OF DECEASED (Type or Print): (First) Elizabeth (Middle) E. (Last) Strange

4. DATE OF DEATH: (Month) July (Day) 28 (Year) 1949

5. SEX: F.

6. COLOR OR RACE: W.

7. SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~ (Specify)

8. DATE OF BIRTH: 11/14/1877

9. AGE last birthday: 72 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Asst. Millinery Store

10b. KIND OF BUSINESS OR INDUSTRY: Millinery

11. BIRTHPLACE (State or foreign country): Annapolis Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert E. Strange

14. MOTHER'S MAIDEN NAME: Caroline M. Yewell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: R. Purnis Strange

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	about 9 hrs
331 83a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterial Hypertension	several yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 27, 1949, to July 28, 1949, that I last saw the deceased alive on July 28, 1949, and that death occurred at 7.57 a m., from the causes and on the date stated above.

SIGNATURE J. Oliver Purnis (Degree or title) M.D. ADDRESS 40 Franklin St Annapolis Md DATE SIGNED 7/28/49

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF 7/30/1949 NAME OF CEMETERY OR CREMATORY St. Annes Cemetery LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. July 28, 1949 REGISTRAR'S SIGNATURE W. J. Bauch

24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS

RECEIVED
JUL 29 1949
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

06448

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN East Port
LENGTH OF STAY (in this place) Dead on arrival
HOSPITAL OR INSTITUTION OR STREET ADDRESS rear 407 Chester Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore-27. (Arbutus)
STREET ADDRESS (If rural, give location) 7843 Louisiana Ave

3. NAME OF DECEASED (Type or Print) (First) Joseph (Middle) J. (Last) Tauber
4. DATE OF DEATH (Month) July (Day) 17 (Year) 1949
5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH 2-5-95
9. AGE last birthday 54 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY Auto mech.
11. BIRTHPLACE (State or foreign country) Jessupo Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Rudolph Taubert
14. MOTHER'S MAIDEN NAME Elanor Hel
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 213-03-0680
17. INFORMANT Gertrude Tauber

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	unknown
	(c)	

420.1
94a

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) 1:55 P m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffy M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Maryland DATE SIGNED 7-17-49

23. BURIAL, CREMATION REMOVAL (Specify) Buried DATE THEREOF July 20-49 NAME OF CEMETERY OR CREMATORY Balto. National Cem LOCATION (City, town, or county) Frederick Av. (State)

DATE REC'D BY LOCAL REG. 7/20/49 REGISTRAR'S SIGNATURE H.W. Hedrick DIV.
24. FUNERAL DIRECTOR Chas. F. Dill ADDRESS 1501 E. Fort Av.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

Evidence for addition of #18c shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06447

CERTIFICATE OF DEATH

FILM No. G 121 AUG 25 1949

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY in this place) 3 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS 216 West Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; STREET ADDRESS (If rural give location) 216 West Street

3. NAME OF DECEASED (Type or Print): (First) Betty (Middle) Ann (Last) Talbot

4. DATE OF DEATH: (Month) 7 (Day) 31 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 12-27-1945

9. AGE last birthday: 3 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Leland Talbot

14. MOTHER'S MAIDEN NAME: May Hassell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT: Leland Talbot

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

096.9 Immediate cause (a) Acute Cardio Vascular Failure — Interval Between Onset and Death: Sudden about 1/2 hr

66 b Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Acute Dehydration & Acute Acidosis — 24 hrs

(c) Probably a virus infection of unknown origin. (8/25/49 - ams.)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 30, 1949, to July 31, 1949, that I last saw the deceased alive on July 30, 1949, and that death occurred at 11 30 A m., from the causes and on the date stated above.

SIGNATURE: J. Oliver Purvis (Degree or title) M.D. ADDRESS Annapolis Md DATE SIGNED 8/1/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF 8-2-49 — NAME OF CEMETERY OR CREMATORY: Cedar Bluff — LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. Aug. 1, 1949 — REGISTRAR'S SIGNATURE: Wm. J. Francis — 24. FUNERAL DIRECTOR: John H. Taylor & Son — ADDRESS

RECEIVED
AUG 3 1949
BUREAU T. S.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

06449

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) about an hour
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. Naval Hospital O.P.D.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 109 Spa View Ave

3. NAME OF DECEASED (Type or Print) (First) Caroline (Middle) Augusta (Last) Taylor
4. DATE OF DEATH (Month) July (Day) 16 (Year) 1949
5. SEX female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widow
8. DATE OF BIRTH Aug. 12, 1888
9. AGE last birthday 60 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME August Fink
14. MOTHER'S MAIDEN NAME Louise Lederer
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Mrs Margaret Rezach

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	Coronary occlusion	sudden
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	Coronary sclerosis	unknown
94a (c)	Arterial Hypertension	unknown

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffy M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 7-16-49

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE THEREOF 7-20-49 NAME OF CEMETERY OR CREMATORY NATIONAL LOCATION (City, town, or county) ANNAPOLIS (State) MD

DATE REC'D BY LOCAL REG. July 18, 1949 REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR JOHN M. TAYLOR + SON ADDRESS ANNAPOLIS MD

RECEIVED
JUL 2[illegible] 1939
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06450

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis

LENGTH OF STAY (in this place) Life

HOSPITAL OR INSTITUTION OR STREET ADDRESS 64 Washington Street

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis

STREET ADDRESS (If rural give location) 64 Washington Street

3. NAME OF DECEASED (Type or Print) (First) Joseph (Middle) A. (Last) Taylor

4. DATE OF DEATH (Month) 7 (Day) 30 (Year) 1949

5. SEX Male

6. COLOR OR RACE Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 5/7/ 1896

9. AGE last birthday 53 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Annapolis, A.A.Co. Md.

12. CITIZEN OF WHAT COUNTRY? ---

13. FATHER'S NAME William Taylor

14. MOTHER'S MAIDEN NAME Henretta Sisco

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ---

16. SOCIAL SECURITY NO. None

17. INFORMANT Margret Taylor

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Myo-Car Dilt — INTERVAL BETWEEN ONSET AND DEATH 1 day

431

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) None

93a

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 29, 1949, to July 30, 1949, that I last saw the deceased alive on July 30, 1949, and that death occurred at 8:00 P m., from the causes and on the date stated above.

SIGNATURE R. L. Richardson (Degree or title) M.D. ADDRESS Annapolis, Md. DATE SIGNED 8/2/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF 8/3/1949

NAME OF CEMETERY OR CREMATORY Brewer Hill Cemetery

LOCATION (City, town, or county) West St. Annapolis, Md. (State)

DATE REC'D BY LOCAL REG. Aug. 3, 1949

REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR Mrs. Charles E. Hicks & Son ADDRESS 45 Northwest St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 4 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

06451

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; MARYLAND LENGTH OF STAY (In this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Spa Creek

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; STREET ADDRESS (If rural, give location) 9 Southgate

3. NAME OF DECEASED (Type or Print): (First) Richard (Middle) Bowen (Last) Taylor

4. DATE OF DEATH: (Month) July (Day) 9 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: 1-8-1942

9. AGE last birthday: 7 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: School

11. BIRTHPLACE (State or foreign country): Charlotte N. C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Clyde C. Tayla

14. MOTHER'S MAIDEN NAME: Edna L. Bowen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT: Clyde C. Tayla Annapolis Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

929.8 **Immediate cause** (a) Drowning

183 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Accidental

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, office building, etc.) OF INJURY Spa Creek (CITY OR TOWN) Annapolis (COUNTY) A. A. (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour) July 9 1949 12:30 p. m. INJURY OCCURRED While at work ☐ Not while at work ☑ HOW DID INJURY OCCUR? Unknown Was missing and Police dragged Creek and found body

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John M. Caffy M.D., Deputy Med. Examiner Annapolis Md 7-11-49

23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF 7-12-49 | NAME OF CEMETERY OR CREMATORY St Mary's | LOCATION (City, town, or county) (State) Annapolis Md.

DATE REC'D BY LOCAL REG. July 11, 1949 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JUL 12 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06452

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville — LENGTH OF STAY (in this place) 4 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 34 Calvert St.,

3. NAME OF DECEASED (Type or Print): (First) Ezekiel (Middle) (Last) Thompson
4. DATE OF DEATH: (Month) 7 (Day) 28 (Year) 1949
5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 1/21/88
9. AGE last birthday: ~~65?~~ (61) yrs. — If under 1 year: Months | Days — If under 24 hrs.: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S
13. FATHER'S NAME: Not Known
14. MOTHER'S MAIDEN NAME: Not known
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331 Immediate cause (a) Cerebral hemorrhage — 2 days

Antecedent cause(s)

83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with cerebral arteriosclerosis — Known to us since adm. 3/11/49

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 11, 1949, to July 28, 1949, that I last saw the deceased alive on July 28, 1949, and that death occurred at 12:10 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Frank Morgenstern M.D. — ADDRESS Crownsville, Maryland — DATE SIGNED 7/28/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE 7/31/49 — NAME OF CEMETERY OR CREMATORY St. Mathews — LOCATION (City, town, or county) (State) Shady Side, Md.

DATE REC'D BY LOCAL REG. July 30, 1949 — REGISTRAR'S SIGNATURE E. F. Joyce Le Roy

24. FUNERAL DIRECTOR Mrs. Charles E. Hicks & Son — ADDRESS 45 Northwest st Annapolis Md.

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AUG 4 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

06453

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY OR TOWN Owensville; LENGTH OF STAY (in this place) 11 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS West River, P.O.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY A. A.; CITY OR TOWN Owensville; STREET ADDRESS (If rural, give location) West River P.O.

3. NAME OF DECEASED (Type or Print): (First) CARRIE (Middle) (Last) TURNER

4. DATE OF DEATH: (Month) July (Day) 18 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow

8. DATE OF BIRTH: Mar. 26, 1887

9. AGE last birthday: 62 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Bristol Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Charles Smith

14. MOTHER'S MAIDEN NAME: Eliza Hanson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Richard Turner

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute Dilatation of Heart	Sudden
442 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 13/a	(b) Cardio-renal-vascular disease	Unknown
	(c) General Arterio-sclerosis	"

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffy (Degree or title) M.D. Deputy Medical Examiner ADDRESS Annapolis, Md DATE SIGNED 7-18-49

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF July 20, 1949 NAME OF CEMETERY OR CREMATORY Dan'l Stan LOCATION (City, town, or county) (State) West River

DATE REC'D BY LOCAL REG. 7/19/49 REGISTRAR'S SIGNATURE S.K. Clayton Dep Reg

24. FUNERAL DIRECTOR J. A. Hardesty & Son ADDRESS Md. Galesville, Md.

RECEIVED
JUL 22 1949
BUREAU V. A.

MARYLAND STATE DEPARTMENT OF HEALTH Bc 116454

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (in this place): 3 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Balt.City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): 133 Asquith Street ✓

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) Augustus (Last) Turner

4. DATE OF DEATH: (Month) 7/26/49 (Day) (Year) 19

5. SEX: male

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 1897

9. AGE last birthday: 52 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): not known

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: not known

14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ******

17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
Immediate cause	(a)	Carcinoma of the Lungs — Known to us since	4/27/49
Antecedent cause(s)			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)		
	(c)	Schizophrenia, Paranoid Type	known since admission 4/27/49

163
472

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: ******

19b. MAJOR FINDINGS OF OPERATION: ******

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): ****** — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: ****** (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): ****** — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?: ******

22. I hereby certify that I attended the deceased from 4/27/49, 19..., to 7/26/49, 19..., that I last saw the deceased alive on 7/26/49, 19..., and that death occurred at 2:50 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Jacob Morgenstern M.D. — ADDRESS: Crownsville, Md. — DATE SIGNED: 7/26/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 8/4/49 — NAME OF CEMETERY OR CREMATORY: Crownsville — LOCATION (City, town, or county) (State): Crownsville, Md.

DATE RECD BY LOCAL REG. 8/3-49 — REGISTRAR'S SIGNATURE: E.T. Joyce L.Reg.

24. FUNERAL DIRECTOR: Supt. Hospital — ADDRESS: Crownsville Md

RECEIVED
AUG 5 1949
BUREAU V. S.

06455

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

T

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ferndale, Md. LENGTH OF STAY (in this place) 24 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3 Vista Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ferndale
STREET ADDRESS (If rural, give location) 3 Vista Ave.

3. NAME OF DECEASED (Type or Print) (First) Rebecca (Middle) Naomi (Last) Wasmus

4. DATE OF DEATH (Month) July (Day) 30 (Year) 1949

5. SEX F Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH July 27, 1880

9. AGE last birthday 69 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Warsaw, Virginia.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Nethanial Wilder

14. MOTHER'S MAIDEN NAME Monorah Gallagher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO. none

17. INFORMANT Frederick H. Wasmus

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

260

Immediate cause (a) Heat Prostration — INTERVAL BETWEEN ONSET AND DEATH 1 day.

(61)

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Diabetes Mellitus — Several years.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 29 1949, to July 30, 1949, that I last saw the deceased alive on July 29, 1949, and that death occurred at 12.25A m, from the causes and on the date stated above.

SIGNATURE John Alexander Md (Degree or title) ADDRESS Glen Burnie Md DATE SIGNED 7/30/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF Aug. 1, 49 NAME OF CEMETERY OR CREMATORY Cedar Hill LOCATION (City, town, or county) Brooklyn, Md. (State)

DATE REC'D BY LOCAL REG. 7/30/49 REGISTRAR'S SIGNATURE L. J. DeAlba

24. FUNERAL DIRECTOR Thomas W. Singleton, ADDRESS Glen Burnie, Md.

RECEIVED
AUG 2 1949
BUREAU V. S.

06456

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emergency Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural, give location) Annapolis

3. NAME OF DECEASED (Type or Print) (First) Carrie (Middle) (Last) Waters

4. DATE OF DEATH (Month) July (Day) 27 (Year) 1949

5. SEX f
6. COLOR OR RACE c
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced
8. DATE OF BIRTH Apr. 2 1888
9. AGE last birthday 61 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10b. KIND OF BUSINESS OR INDUSTRY Domestic
11. BIRTHPLACE (State or foreign country) A. A. Co.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Brown
14. MOTHER'S MAIDEN NAME Ann Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Sarah Sharps

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
	Immediate cause	(a) cerebral hemorrhage	5 days
331	Antecedent cause(s)		
83a	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) hypertension	
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 22nd, 1949, to July 27, 1949, that I last saw the deceased alive on July 27, 1949, and that death occurred at 3 10 P m., from the causes and on the date stated above.

SIGNATURE Edith Rodler (Degree or title) M.D. ADDRESS 42 State Circle Annapolis, Md. DATE SIGNED 7-28-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE July 31, 1949
NAME OF CEMETERY OR CREMATORY Union Chapel
LOCATION (City, town, or county) (State) Bristol, Md.

DATE REC'D BY LOCAL REG. July 31, 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR J.B. Johnson ADDRESS Annapolis, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 3 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH TN 016457

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville; MARYLAND; LENGTH OF STAY (In this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Severn Rivers at Herald Harbor

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Prince George; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Seat Pleasant; STREET ADDRESS (If rural, give location) 6801 - C. Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
PHILIP	EDGAR	WELLS	July	31	1949

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hr.: Hours	Min.
Male	White		Feby. 4, 1939	10 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student	School	Seat Pleasant, Maryland	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Horace R. Wells	Alice C. Welsh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
	—	Wilbert Rittershofer

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Drowning	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Accident	
	(c)	

929.8
193

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐	PLACE (Home, farm, factory, street, office, etc.) OF INJURY Severn River	(CITY OR TOWN) near Crownsville	(COUNTY) A. A.	(STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☑	HOW DID INJURY OCCUR?
July 31, 1949 6:20 p.m.		Was in bathing and disappeared in 10 feet of water

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John M. Coffey	M.D., Deputy Medical Examiner,	Annapolis Md	7-31-49

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Aug. 3, 1949	Fort Lincoln Cemetery	Prince George County,	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8/1049	E. F. Joyce Local Reg	Warner E. Pumphrey, Inc.	Silver Spring, Md.

RECEIVED
AUG 12 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH Bc 06458

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 25

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasadena P.O. | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Maryland Beach

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore - 25
STREET ADDRESS (If rural, give location) 3602 West Bay Av. ✓

3. NAME OF DECEASED (Type or Print): (First) Peggy (Middle) Jean (Last) Whidby
4. DATE OF DEATH: (Month) July (Day) 14 (Year) 1949
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH: Jany. 25, 1933
9. AGE last birthday: 16 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: High School
11. BIRTHPLACE (State or foreign country): Atlanta, Georgia
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: Roy Henry Grady Whidby
14. MOTHER'S MAIDEN NAME: Dorothy Helma
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Roy H.G. Whidby

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Drowning
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Accidental
(c)

929.4
183

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Chesapeake Bay | (CITY OR TOWN) | (COUNTY) A.A.Co. | (STATE)
TIME OF INJURY (Month) July (Day) 14 (Year) 1949 (Hour) 4:20 p.m. | INJURY OCCURRED While at work ☐ Not while at work ☒ | HOW DID INJURY OCCUR? Dove off boat in 14 feet water in Bay

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
John M. Claffy M.D. Deputy Medical Examiner, Annapolis Md 7-15-49

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State)
Burial | 7-19-49 | West View | Atlanta, Georgia

DATE REC'D BY LOCAL REG. July 16, 1949 | REGISTRAR'S SIGNATURE Ida M. Whitson

24. FUNERAL DIRECTOR James L. McCurdy | ADDRESS 130 E. Fort Rd

RECEIVED
JUL 15 1949
BUREAU F. S.

06459

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH· COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED· STATE: Maryland COUNTY: ~~At Large~~ Dordrecht
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Vienna
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): not known ✓

3. NAME OF DECEASED (Type or Print)	(First) Thomas	(Middle)	(Last) Williams	4. DATE OF DEATH (Month) 7/25/49 (Day) (Year) 19
5. SEX: male	6. COLOR OR RACE: colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: ~~not known~~ 1893	9. AGE last birthday: 56 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer	10b. KIND OF BUSINESS OR INDUSTRY: none	11. BIRTHPLACE (State or foreign country): Butler, Ala.	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME: not known		14. MOTHER'S MAIDEN NAME: Lue Williams		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ****** (If year, give war or dates of service) **********	16. SOCIAL SECURITY NO. *******	17. INFORMANT: Hospital Records		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
002 Immediate cause	(a) Tuberculosis of Lungs	known
Antecedent cause(s)		since 6/3/49
30b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) General Paresis	knownsince admission

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: **********	19b. MAJOR FINDINGS OF OPERATION: **********	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify) **********	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ********** (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) ********** m.	INJURY OCCURRED While at Work ☐ Not While At work ☐ **********	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/21/49, 19....., to 7/25/49, 19....., that I last saw the deceased alive on 7/25/49, 19....., and that death occurred at 4:00 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Morgenstern M.D.		Crownsville, Md.	7/26/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: 8/4/49	NAME OF CEMETERY OR CREMATORY: Crownsville	LOCATION (City, town, or county) (State): Crownsville, Md.
DATE REC'D BY LOCAL REG.: 8-3-49	REGISTRAR'S SIGNATURE: E. F. Joyce L. Reg.	24. FUNERAL DIRECTOR: Supt Hospital	ADDRESS: Crownsville Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 5 1949
BUREAU V. S.

06460

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Odenton LENGTH OF STAY (in this place) 45	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Odenton
HOSPITAL OR INSTITUTION OR STREET ADDRESS —	STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED (Type or Print)	(First) Charles	(Middle)	(Last) Wilson	4. DATE OF DEATH	(Month) 7	(Day) 16	(Year) 1949
5. SEX Male	6. COLOR OR RACE Black	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH Aug 4, 1869	9. AGE last birthday 79 yrs.	If under 1 year Months.	Days	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Watchman	10b. KIND OF BUSINESS OR INDUSTRY Penn R.R.	11. BIRTHPLACE (State or foreign country) U.S.	12. CITIZEN OF WHAT COUNTRY? U.S.				
13. FATHER'S NAME John Wilson	14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If year, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT Alice Wilson - Wife					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Arterio-sclerotic Heart Disease	3 weeks
241 Antecedent cause(s)		
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Asthma	26 years
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1946, to July 15, 1949 that I last saw the deceased alive on July 11, 1949, and that death occurred at 11:30 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Edward J Thewitt	M.D.	Gambrills Md	July 15, 49

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify)	DATE July 19/1949	NAME OF CEMETERY OR CREMATORY Mt Tabor,	LOCATION (City, town, or county) Chesterfield Ad. (State) Md
DATE REC'D BY LOCAL REG. July 19, 1949	REGISTRAR'S SIGNATURE E. F. Joyce Local Reg	24. FUNERAL DIRECTOR J. B. Johnson,	ADDRESS Annapolis,

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUL 25 1949
BUREAU T. S.

06461

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Ft. Meade
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address/where death occurred: Ft. Meade Station Hospital
How long in hospital or institution? 8 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County: Henrico
City or town: Richmond
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 105 Clay Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Roger Lee Winston Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 14, 1946

8. AGE: Years	Months	Days	If less than one day
3	5	15	hrs. min.

8. Birthplace: Richmond, Virginia (Town, county, and state)
10. Usual occupation:
11. Industry or business:
FATHER 12. Name: Roger L Winston Sr
13. Birthplace: Virginia
MOTHER 14. Maiden name: Mary Brown
15. Birthplace: Virginia
16. Informant: Roger L Winston Sr
Address: Fort Geo G Meade, Maryland
17. Removal (Burial, cremation, or removal. Which?) Date thereof: July 28 49 (month) (day) (year)
Cemetery or crematory: Woodlawn
Location: Highland Park, Richmond, Virginia
18. Funeral director: C.R. Law
Address: Baltimore, Maryland
19. 3 Aug 1949 (Date rec'd by registrar)
E. R. BUNSIDE, Capt., MSC Registrar
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 28 July 1949, at 0005 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19... to ... 19...
and that I last saw h.. alive on 28 July 1949

Immediate cause of death	DURATION
Heart Failure	8 Hrs.
Due to: INTRa VENTRICULAR SEPTAL DEFECT	
Due to: CONGENITAL MALFORMATION	
Other conditions: RHEUMATIC CARDITIS (OLD)	

754.2
757.2
(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results: Congenital heart
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. S. MITCHENER JR. M. D.
Address: Ft Geo G Meade, Md. Date signed: 28 July

RECEIVED
AUG 8 1949
BUREAU V. S.

06462

MARYLAND STATE DEPARTMENT OF HEALTH Bc

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasadena, P.O
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Maryland Beach

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 4011 - Woodridge Road

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Lucille (Last) Wynne
4. DATE OF DEATH (Month) July (Day) 4 (Year) 1949
5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) —
8. DATE OF BIRTH Apr. 3 1941
9. AGE last birthday 8 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY School
11. BIRTHPLACE (State or foreign country) Baltimore Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME Edward J. Wynne
14. MOTHER'S MAIDEN NAME Margaret F. Brennan
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Edward J. Wynne

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Drowning

929.4 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Accidental

183 (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Maryland Beach (CITY OR TOWN) Pasadena P.O. (COUNTY) A.A. (STATE) Md
TIME OF INJURY (Month) July (Day) 4 (Year) 1949 (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☑
HOW DID INJURY OCCUR? Was in bathing at Maryland Beach

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffy M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 7-4-49

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE THEREOF JULY 7 '49
NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL
LOCATION (City, town, or county) BALTO. MD (State)
DATE REC'D BY LOCAL REG. [illegible]
REGISTRAR'S SIGNATURE [illegible]
24. FUNERAL DIRECTOR Harry H Witzke - 4101 Edmondson Ave ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

Dr. Arends
Annapolis

RECEIVED
JUL 9 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

06463

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Severn; LENGTH OF STAY (in this place) 16 months; HOSPITAL OR INSTITUTION OR STREET ADDRESS New Cut Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY A. A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Severn; STREET ADDRESS (If rural give location) New Cut Road

3. NAME OF DECEASED (Type or Print): (First) JUOZAS (Middle) ANTHONY (Last) ZAUKUS

4. DATE OF DEATH: (Month) July (Day) 13 (Year) 1949

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH: NOV. 1872

9. AGE last birthday: 76 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Iron Molder

10b. KIND OF BUSINESS OR INDUSTRY: Steel

11. BIRTHPLACE (State or foreign country): Lithuania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Anthony Zaukus

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Frank Zaukus - Son

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Hypertensive Cardio-Vascular Disease — years

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis general

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

443
932

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 6, 1949, to July 13, 1949, that I last saw the deceased alive on July 12, 1949, and that death occurred at 1:40 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

Bobby L. Jones M.D. 7 Central Ave SW. Glen Burnie 7/13/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF July 16-49 — NAME OF CEMETERY OR CREMATORY Holy Cross Cem. — LOCATION (City, town, or county) (State) Anundel County Md

DATE REC'D BY LOCAL REG. 7/15/49 — REGISTRAR'S SIGNATURE L. W. Skedrich

24. FUNERAL DIRECTOR — ADDRESS

Joseph Kaunakas Inc 602 Wash. Blvd